Delta Dental Plan for Retired PNNL Staff

Of Battelle Memorial Institute

Plan Document and Summary Plan Description

Table of Contents

Important Information 4
Eligibility 6
Eligible Groups 6
Eligibility Requirements for Retirees 6
Eligibility Requirements for Disabled Participants 7
Eligibility Requirements for Certain Transfers within Battelle Control Group 7
Ineligble Staff Members 8
Enrollment 10
Dependent Verification 10
Contributions and Costs 12
Waiver of Participation 12
Coverage Effective Date 12
How to Obtain Covered Services 13
Accessing Benefits 14
Network and Non-Network Benefits 14
Eligible Expenses 15
Pre-Determination of Benefits 16
Schedule of Benefits 16
Covered Services 17
Exclusions and Limitations 19
Exclusions 20
Limitations 23
Termination of Coverage 26
For all Participants and Enroll Dependents: Late Payment or Non-Payment of Premiums 26
Retired Participants 27
Participants on Long Term-Disability 27
Enrolled Dependents 27
Loss of Dependent Status 28
Other Events Ending Your Coverage 28
Death of a Participant 29
Federal Continuation of Coverage (COBRA) 30
Qualifying Events 30

Qualified Beneficiary Responsibility 30
How to Elect COBRA Coverage 31
Eligibility and Premiums 32
Coordination of Benefits 34
Overpayments 35
Subrogation and Rights of Reimbursement 36
Condition of Participation 36
Requirement of Cooperation 37
Circumstances beyond the Control of the Plan 38
Protected Health Information under HIPAA 39
Claims Procedures 40
How to Obtain Benefits 40
Filing a Claim for Out-Of-Network Benefits 40
Required Informaiton for Claims Submission 41
Payment of Benefits 41
Post-Service Claim 41
Pre-Service Claim 42
Concurrent Care Claims 42
Explanation of Benefits 42
Appeals 44
Denial Notice 44
What to Do First 44
What to Do if You are Denied on Appeal 46
Benefit Determination 46
How to Appeal A Denial of Eligibility Or Enrollment 46
Definitions 47
Administrative and Contact Information 54
Statement of ERISA Rights 56

Important Information

Plan Documentation

The following is the legal Plan document and Summary Plan Description ("SPD") for the Battelle Memorial Institute Dental Plan for BMI Retirees, commonly known as the Delta Dental Plan for Retired PNNL Staff of Battelle Memorial Institute (the "Plan") as of January 1, 2011. The Plan is a self-insured welfare benefits plan providing group dental benefits. Battelle Memorial Institute is the Plan Sponsor and Plan Administrator of the Plan.

The Plan is called "self-insured" because Battelle Memorial Institute ("Battelle"), as opposed to an insurance company, assumes the risk for funding all benefits under the Plan. Although the Plan is self-insured, Battelle contracts with a third party administrator to process claims incurred under the Plan according to the terms of the Plan document and industry standards.

This Plan Document and SPD, prepared by the Plan Administrator, is a written statement to inform you about the coverage, how to access dental care, what portion of the dental care costs you will be required to pay, and any limitations, exclusions, and requirements that apply within the Plan. This document replaces and supersedes any Plan Document and SPD that you have received previously.

This document and any Amendments and attachments are intended to constitute the Plan document as required by Section 402 of the Employee Retirement Income Security Act of 1974 ("ERISA") and the SPD as required by Section 102 of ERISA. Please refer to this document for information regarding Benefits provided under the Plan. This revised Plan Document and SPD is effective January 1, 2011.

Many words used in this Summary Plan Description and Plan Document have special meanings. These words appear in capital letters and are defined for you. Refer to these definitions in the 'Definitions' section of this document for the best understanding of what is being stated.

Please be aware that your Dentist does not have a copy of this document, and is not responsible for knowing or communicating your benefits to you.

Claims Administration

Battelle has delegated much of the day-to-day administration of the Plan to the Plan's third party administrator, Delta Dental (the "Claims Administrator"). The Claims Administrator has discretionary authority to make benefit determinations under the Plan. Benefit determinations include determining eligibility for benefits, claims processing, and interpreting and enforcing the provisions of the Plan according to the terms of the Plan.

Contributions from Participants who are employees of Battelle Corporate Operations are held in the Battelle Employee Dental Benefits Trust until distributed, and are used exclusively for the benefit of such Participants and/or their Dependents for funding the Plan. The Battelle Employee Dental Benefits Trust is a "voluntary employee beneficiary association" under Internal Revenue Code Section 501(c)(9). Any funds contributed by Participants that are remaining in the trust upon the

termination of the Plan and after all obligations are fulfilled shall be devoted to other employee benefits in accordance with the conditions of the Battelle Employee Dental Benefits Trust.

Staff may contact **Delta Dental** via:

Phone
Delta Dental Customer Service Representatives are available Monday through Friday, 5:30 A.M. – 4:50 P.M. Pacific Time at (800) 524-0149.

Internet
The Delta Dental web address is www.DeltaDentalOH.com. The website may be used to find general information and names of participating Dentists near you. When you search for dental providers, you can search the Delta Dental PPO℠ network or the Delta Dental Premier® Network. First, click **"Enrollees"** on the left hand side of the page. Under "Enrollees" click **"Find a Provider"** and then click **"Delta Dental."** Finally select **"Delta Dental PPO"** or **"Delta Dental Premier."** You can search by dentist name, location, or specialty. Participants can also register at www.DeltaDentalOH.com with the **"Consumer Toolkit."** To register using the "Consumer Toolkit" First, click **"Enrollees"** on the left hand side of the page. Under "Enrollees" click **"Consumer Toolkit."** Registered members receive personalized service such as the ability to verify eligibility, check covered benefits and maximums, review claims and claim payments, print your own Identification Card, print a claim form, and stop delivery of paper Explanation of Benefits (EOB) statements and instead view all of your EOB's online.

Claims Submittal Address for Dental Claims
Delta Dental
P.O. Box 9085
Farmington Hills, MI 48333-9085

Requests for Review of Denied Dental Claims
Delta Dental
Dental Director
P.O. Box 30416
Lansing, MI 48909-7916

Group Number
1033

Plan Effective Date

January 1, 2011

Eligibility

Waiting Period

As an Eligible Person, you may elect coverage under the Plan that is effective for yourself and your eligible Dependents within the month of your termination of employment for retirement provided you meet all applicable eligibility requirements of the Plan.

Eligible Groups

An "Eligible Employer" is Pacific Northwest Division of Battelle Memorial Institute.

An "Eligible Person" is a former staff member who meets all of the eligibility requirements in the Plan and immediately before retiring or becoming disabled was either:

- A staff member designated as a salaried employee of an Eligible Employer for payroll purposes; or
- A full-time hourly employee of an Eligible Employer who was covered by a collective bargaining agreement with an Eligible Employer.

When an Eligible Person actually enrolls, that person is called a Participant. If both Spouses are Eligible Persons, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.

The Plan Administrator determines who is eligible to enroll under the Plan.

Eligibility Requirements for Retirees

You are eligible to participate in the Plan upon your retirement from Active Service, if as of the date of such retirement you meet <u>all</u> of the following requirements:

- You are age 55 with 10 or more Years of Credited Service after June 30, 1976.
- You earned at least three consecutive Years of Credited Service in a continuous period of employment ending on your retirement date.
- You are covered under a Battelle-sponsored dental care plan.
- You immediately commence pension benefits from a Battelle-sponsored qualified retirement plan.

If you do not elect coverage under the Plan at the time of retirement from Active Service, you will not be eligible to elect coverage under the Plan at a later date except as provided for Spouses in Active Service (not retired).

Eligibility Requirements for Disabled Participants

You are eligible to continue coverage after termination of employment for disability, regardless of age or Years of Credited Service, if you meet all of the following requirements:

- You incur a disability as an Active staff member from an Eligible Employer
- That same disability qualifies you for benefits from the Battelle Pacific Northwest Laboratories Employees' Long-Term Disability Plan (the "PNNL LTD Plan")
- You are covered by a Battelle-sponsored dental plan as of the day prior to beginning benefits under the PNNL LTD Plan
- You have received at least 24 months of benefits (including retroactive payments, if applicable) from the PNNL LTD Plan.

After 24 months of benefits from the PNNL LTD Plan, you are reclassified for purposes of this Plan from Long-Term Disability Leave-Without-Pay status to Long-Term Disability Retirement Status. You must complete a Battelle Retirees' Medical and Dental Plan Enrollment and Change Form and return it to your Benefits Office no later than the end of the month in which your employment status is reclassified to LTD retirement. Your coverage will continue at the same level of coverage with the same dependents as you had under the Battelle-sponsored dental plan prior to beginning coverage under the Plan. If you fail to complete the enrollment form, you will be automatically enrolled into the Plan.

Your coverage under the Plan due to your disability will end the earlier of when:

- Your benefits from the PNNL LTD Plan terminate; or
- You reach age 65.

If your PNNL LTD Plan benefits continue past your age 65, you may continue to participate in the Plan only to the extent that you have met the requirements for participation as a retiree, other than the requirement to retire from Active Service.

Eligibility Requirements for Certain Transfers Within Battelle's Controlled Group

If you transfer from employment with Battelle to employment with a member of Battelle's controlled group or a subsidiary that is at least 51%-owned by Battelle or Battelle's controlled group (a "Battelle Group Member"), you maintain your eligibility for this Plan until your termination of employment with the Battelle Group Member (even if subsequently less than 51%-owned by Battelle or Battelle's controlled group.) In addition, if you return directly to employment with Battelle from the Battelle Group Member (even if Battelle's or its controlled group ownership is reduced to less than 51%), you maintain your eligibility for the Plan provided that the service with Battelle and the Battelle Group Member is continuous and uninterrupted. (However, only certain salaried service with Battelle and/or participating employers can count as Years of Credited Service.) In order to maintain eligibility under this provision, you must enroll in the Plan immediately upon your

termination of continuous employment with Battelle and the Battelle Group Member, and coincident with your commencement of pension benefits under a Battelle-sponsored pension plan.

Ineligible Staff Members

You and your Dependents are not eligible to participate in the Plan if you are not working for an Eligible Employer listed in the 'Eligible Groups' section of this document at the time of your retirement. In addition, individuals performing services for Battelle in any of the following categories (as determined by Battelle) are not eligible to participate in the Plan:

- Individuals treated as independent contractors
- Contractor's employee
- Union employee, except as provided in a collective bargaining agreement between the union and Battelle
- Any member of the Board of Directors of Battelle who is not an eligible employee
- Visiting professors
- Spouse/Registered Partner performing military service
- Interns and/or co-op students
- Any person employed outside of the U.S. by a foreign-based subsidiary or division of Battelle
- Temporary, leased, and seasonal employees.

Definition of Active Employment/Actively at Work/Active Service

Active Employment, Actively at Work, and Active Service means you are working for an Eligible Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation on a day that is one of your Eligible Employer's scheduled workdays. You must be working in an eligible employment classification as described under the 'Eligible Groups' section of this document. Your work site must be your usual place of business, an alternative work site (including your home) at the direction of your manager, or a location to which your job requires you to travel. Normal paid time off (vacation) is considered Active Employment.

You are considered to be "Active" or in "Active Service" on a day that is not one of your Eligible Employers' scheduled workdays only if you performed in the customary manner all of the regular duties of your salaried employment on the next preceding scheduled workday.

Notwithstanding the foregoing, solely for purposes of eligibility for this Plan, you are considered to be in "Active Service" during the period for which you are eligible for continuation of medical and dental benefits under Battelle Operating Guide policy 140-4 "Involuntary Terminations- Severance Pay."

Eligible Dependents

Eligible Persons as defined in the 'Eligible Groups' section of this document, have the opportunity to elect coverage for their Dependents. When a Dependent actually enrolls, that person is called an Enrolled Dependent. In order for an individual to be eligible for coverage as a Dependent of a

Participant, the Participant must be enrolled in the Plan, must elect a level of coverage that includes the Dependent, and the Dependent must meet the eligibility requirements of the Plan. In addition, the Dependent must have been covered by a Battelle-sponsored dental plan as a dependent of the Participant on the day before coverage under the retiree Plan started. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent. The Plan Administrator determines who qualifies as a Dependent. The following are eligible Dependents under the Plan:

- Your lawful Spouse/Registered Partner. However, you may not cover your Spouse/Registered Partner as a Dependent if your Spouse/Registered Partner is enrolled for coverage as an employee for an Eligible Employer listed in the 'Eligible Groups' section of this document.

- Your unmarried Dependent Child, who is up to, but not including, age 23. A Child for plan purposes is your natural or adopted child, a child placed with you for adoption, a stepchild or any other child who resides in your home who can legally be claimed as your tax dependent. A Dependent also includes a child for whom dental coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

  A child may not be covered by more than one Participant for Plan purposes (e.g., for a child of married Participants). A Child will be eligible for coverage under the Plan only until the end of the month in which he or she loses status as a Dependent under the Plan.

- Your unmarried child who is 23 years of age or over and who is mentally or physically incapable of self-sustaining employment may qualify for continued Dependent coverage. In order to qualify, the Dependent must meet all requirements for a Dependent under the Plan other than age, and must be primarily dependent upon you for support. Proof of mental or physical incapacity satisfactory to the Plan Administrator and evidence that the Dependent is primarily dependent upon you for support, must be submitted to the Plan Administrator within 31 days of failure to qualify as a Dependent solely because of attainment of age 23. If this applies to your dependent, please complete and return an "Application for Continuation of Coverage" form to your Benefits Office. Your Dependent must have been covered under this Plan as your Dependent when he or she attained age 23 and the incapacity must have commenced before the Dependent reached age 23. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

  If you are a newly Eligible Person with a Disabled Dependent, within 31 days of your initial eligibility you must submit to the Plan Administrator proof as required above demonstrating your Dependent's continuing incapacity for self-sustaining employment beginning prior to age 23. In addition, you must provide evidence that your Dependent is primarily dependent on you for support and was covered by a group plan immediately prior to submitting your application for coverage under this Plan. If approved, coverage is retroactive to the date of eligibility. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

The Plan Administrator may require a Participant to reimburse the Plan for any Benefits that the Plan pays for a Dependent at a time when the Dependent did not satisfy these conditions.

In order to elect coverage for your Dependents you must elect coverage for yourself.

For additional details on who is a Dependent, please refer to the definition of Dependent.

Enrollment

Dental Enrollment Deadlines

Your participation in dental coverage under the Plan is voluntary. Upon enrollment in the Plan for dental coverage, and as a condition to participation in and receiving Benefits from the Plan, you and your Enrolled Dependents are subject to the Plan's terms as set forth in this document, and also as provided from time to time by the Plan Administrator or its delegates.

Coverage must be elected no later than the end of the month in which you terminate employment or retire by completing and returning the Battelle Retirees' Medical and Dental Plan Enrollment and Change Form to your Benefits Office. The Plan Administrator has the full and exclusive discretionary authority to determine eligibility under the Plan.

If you do not elect coverage under the Plan at the time of retirement from Active Service, you will not be eligible to elect coverage under the Plan at a later date except as provided for Spouses in Active Service (not retired).

If you do not elect coverage under the Plan at the time your employment status is reclassified to LTD Retirement, you will be automatically enrolled in the Plan.

Dependent Verification

Employees must provide the following applicable documentation for any newly added Dependent:

Spouse:

- A photocopy of your most recent tax return*, or
- A photocopy of your marriage certificate if married during the current year.

Your Child or Stepchild:

- A photocopy of your most recent tax return*; or
- For children born during the current year:
    1. A photocopy of the child's birth certificate(s) showing the employee as the parent; or

2. Legal documentation of adoption or placement for adoption; or

- A court order or divorce decree dictating that the retiree or disabled staff member provides health insurance for the child; or

- A Divorce decree establishing the retiree or disabled staff member's spouse:

  1. As the custodial parent; or
  2. must provide health coverage

  and other documentation establishing that child resides with the retiree or disabled staff member.

Registered Partner:

- A photocopy of your Certificate of Registration for Domestic Partnership, and
- A photocopy of the most recent tax return* for you and your Registered Partner.

*If you provide tax documents as your proof of dependency we will require two pages:

1. The first page of your 1040 form, and
2. One of the following:

   - Page two of your 1040 form showing your signature, or "prepared by" if a third party did your taxes
   - The electronic postmark page, if you filed electronically
   - The e-mail confirmation that your return was accepted, if you filed electronically, or
   - The e-file signature authorization, if your tax preparer filed electronically on your behalf.

Please conceal the first five digits of social security numbers and all income amounts.

Deferral of Enrollment in the Plan Where Spouse is a Staff Member in Active Service.

If, at the time you first become an Eligible Person under this Plan, you are covered (or eligible for coverage) as a dependent of your Spouse in a Battelle-sponsored dental plan for active (not retired) staff, you may defer enrollment for so long as you remain continuously covered as a dependent of your Spouse under a Battelle-sponsored dental plan. However, you must enroll in this Plan as of the first of the month after such coverage as a dependent ends in order to maintain your eligibility for this Plan. The enrollment form must be received by the Benefits office by the 7th of the month in which your coverage as a dependent ends unless evidence satisfactory to the Plan Administrator of a hardship making it impossible for you to timely provide such enrollment form is submitted to the Benefits office before the end of the month after your coverage ended. If you do not timely elect coverage under the Plan at the time your coverage ends as a dependent of an active (not retired) staff member, you will not be eligible to enroll in the Plan at a later date.

You do not have to elect coverage under the Plan. Alternatively, if at the time your Spouse reties, he or she is eligible for and elects to participate in the Plan, your Spouse may cover you as a Dependent. However, once you are an Enrolled Dependent under the retiree dental Plan, you will not maintain eligibility for enrollment as a Participant. Please review the provisions regarding Dependent coverage carefully prior to making your decision, as your coverage as a Dependent may end sooner than if you had your own coverage as a Participant.

Contributions and Costs

The Plan is a self-insured dental plan, which means that Battelle assumes the risk for funding all benefits and administrative costs paid by the Plan. Participants' contributions offset a portion of these costs. Battelle currently determines Participant contribution rates under the Plan and communicates contribution rates to Eligible Persons prior to the beginning of each calendar year. Battelle reserves the right to raise and/or otherwise change contributions for coverage under the Plan, or to cease coverage under the Plan entirely.

Payment of Plan Contributions

Premium payments are due in advance of coverage on the first day of each calendar month. Your applicable premium payment will be deducted from your pension check provided that the monthly pension is sufficient to cover premiums. Alternatively, premium payments may be paid by personal check or money order, made payable to "Battelle". Send payments to:

PayFlex Systems USA, Inc.
Attn: Benefits Billing Department
P.O. Box 2239
Omaha, NE 68103-2239

Waiver of Participation

Participation in the Plan is voluntary and not a condition of employment. Participation is subject to the conditions specified in the Plan and such other conditions determined by the Plan Administrator to be necessary or desirable for the administration of the Plan.

Any person who has waived participation in the Plan is not eligible to participate in the Plan. A person is considered to have "waived participation" in the Plan as of the earlier of receipt of a written waiver of participation acceptable to the Plan Administrator, or the refusal to provide information deemed necessary or desirable by the Plan Administrator for the administration of the Plan.

Coverage Effective Date

Coverage begins on the Participant's retirement date if the Benefits Office receives the completed enrollment form by the end of the month in which the Participant terminates employment to retire, or after 24 months of PNNL LTD Plan payments (including retroactive payments, if applicable). Under the Plan terms, once you have made an election for dental coverage under the Plan, it is fixed except as otherwise provided in the Plan. Therefore, you should consider your elections carefully.

Qualified Medical Child Support Order (QMCSO)

The Plan will allow enrollments and election changes during the calendar year as required by a qualified court order requiring dental care coverage for the Child of a Participant. The court order must be submitted to the Plan Administrator for determination. An order cannot provide for a new type, form, or option of benefit not otherwise provided in the Plan. In addition, the Plan will allow a Participant to drop coverage for a Dependent during the calendar year upon receipt of:

- A qualified court order providing for coverage of the Dependent under a Spouse's or former Spouse's plan; and
- Written documentation satisfactory to the Plan Administrator that the Child is in fact covered under the other plan.

The order will be effective prospectively only from the date the order is determined to be qualified. A copy of the Plan's procedures governing Qualified Medical Child Support Orders (QMCSO) is available from the Plan Administrator at no charge.

How to Obtain Covered Services

Relationship of Parties (Battelle and the Claims Administrator)

The relationships between the Claims Administrator and Battelle as the Plan Sponsor and the Plan Administrator are solely contractual relationships between independent parties. The Claims Administrator is not Battelle's agent or an Employee of Battelle. Neither Battelle nor any of Battelle's employees are agents or employees of the Claims Administrator.

Neither Battelle, as Plan Sponsor and Plan Administrator, nor the Claims Administrator, provide Dental Services or supplies or practice dentistry.

The Claims Administrator is not considered to be an employer or Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan Administrator is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- Notifying you of the termination of or modification to the Plan.

Not Liable for Provider Acts or Omissions

The Claims Administrator and/or the Plan Administrator are not responsible for the actual care you receive from any person. The Plan does not give anyone any claim, right, or cause of action against the Claims Administrator and/or the Plan Administrator based on what a provider of dental care, services or supplies, does or does not do.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Network Providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and Battelle is that of employer and employee, Dependent of a Participant or other classification as defined in the Plan.

Accessing Benefits

Only Necessary Dental Services and Dental Procedures are eligible for Benefits under the Plan. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is covered under the Plan.

You can choose to receive treatment from any licensed Dentist or other appropriate provider. Benefits are available only if all of the following are true:

- Covered Dental Services are received while the Plan is in effect
- Covered Dental Services are received prior to the date that any of the individual termination conditions listed in the 'Termination of Coverage' section of this document occurs
- The person who receives Covered Dental Services is a Covered Person and meets all eligibility requirements specified in the Plan

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing dental research, based on well-conducted randomized trials or cohort studies, as described.

Network and Non-Network Benefits

The Claims Administrator owns two dental networks: Delta Dental PPO and Delta Dental Premier. These Network Providers have agreed to discount their charges for Covered Dental Services and will fill out and file claim forms for you.

If a Covered Person receives services from a Network Provider, the amount of Eligible Expenses for which a Covered Person is responsible will generally be less than the amount owed if the Covered Person receives services from a Non-Network Provider.

You will save the most money by visiting a Delta Dental PPO Dentist. The Claims Administrator will pay the PPO Dentist directly for Covered Services based on the submitted fee or the amount in the local Delta Dental's PPO Dentist schedule, whichever is less. If the PPO Dentist schedule amount is lower than the Dentist's submitted fee, the Dentist cannot charge you the difference. This means

you will be responsible only for your Coinsurance and Deductible, if any, when you go to a PPO Dentist for Covered Services.

Although you will receive a lower level of coverage for some services when you go to a Premier Dentist, the Claims Administrator will pay the Premier Dentist directly for Covered Services based on his or her submitted fee or the local Claims Administrator's maximum approved fee, whichever is less. If the maximum approved fee is lower than the Dentist's submitted fee, the Dentist cannot charge you the difference. As with PPO Dentists, this means you will be responsible only for your Coinsurance and Deductible, if any, when you go to a Premier Dentist for Covered Services.

It is your responsibility to determine whether or not a provider is in the Network. A Covered Person can visit the Claims Administrator's website or call Customer Service to obtain a list of customized, local providers who participate in the Network. See the 'Important Information' section of this document for additional information.

Network Providers are responsible for submitting a claim for payment directly to the Claims Administrator; however, a Covered Person is responsible for any Coinsurance at the time of service. If a Network Provider bills a Covered Person for amounts in excess of the "Patient Obligation" on the Explanation of Benefits (EOB), Customer Service should be called. A Covered Person does not need to submit claims for Network Provider services or supplies.

When you receive Covered Dental Services from a Non-Network Provider, you are responsible for requesting payment from the Plan through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described in the 'Claims Procedures' section of this document.

Eligible Expenses

The Plan Administrator has Delegated to the Claims Administrator the discretion and authority to initially determine on the Plan's behalf whether a treatment or supply is a Covered Dental Service and how the Eligible Expense will be determined and otherwise covered under the Plan.

For Network Benefits, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills, unless you agreed to reimburse the provider for such services. For Non-Network Benefits, you are responsible for paying, directly to the Non-Network Provider, any difference between the amount the provider bills you and the amount the Plan will pay for Eligible Expenses.

Alternate Benefit Provision

When more than one Covered Dental Service could provide suitable treatment based on common dental standards, the Claims Administrator will determine the Covered Dental Service on which payment will be based and the expenses that will be included as Eligible Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed the payment for

Eligible Expenses. For this reason, it is strongly recommended that you contact the Claims Administrator for a predetermination of benefits when major Dental Services are needed.

Pre-Determination of Benefits

Pretreatment Review is available on a voluntary basis when extensive dental work in excess of $200 is proposed. You should notify the Claims Administrator of such treatment before treatment begins. If requested the Dentist must provide the Claims Administrator with dental X-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination. The Claims Administrator, on behalf of the Plan Administrator, will decide if the proposed treatment is covered under the Plan and estimate the amount of payment. The estimate of Benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Plan. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by the Claims Administrator. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

Schedule of Benefits

The Schedule of Benefits is a summary of the Deductible, Coinsurance and other limits when you receive Covered Services from a Dentist. Please refer to the 'Covered Services' section of this document for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of the Summary Plan Description and Plan Document including any attachments or Amendments.

This Schedule of Benefits lists the Covered Person's responsibility for Covered Services.

Description	**Amounts**	
Benefit Period	Calendar Year	
Dependent Age Limit	Up to, but not including, age 23.	
Annual Deductible*		
Per Person	$ 50	
Per Family	$150	
Coinsurance**	Class I- Preventive & Diagnostic Care	Covered in full
	Class II- Basic Restorative Care	Covered after the Deductible at 80%.
	Class III- Major Restorative Care	Covered after the Deductible at 50%.

Description	Amounts
Calendar Year Maximum for Dental Covered Services ***	$1,500 per Covered Person per calendar year

*The Annual Deductible is the amount you must pay each calendar year for Covered Dental Services before the Plan begins paying for Eligible Expenses. The Deductible does not apply to Diagnostic and Preventive services, Emergency Palliative Treatment, Brush Biopsy, X-rays (except for cephalometric films), and Sealants.

**Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Dental Services after you meet the Annual Deductible. You must pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expenses. For example, let's assume that you receive Plan Benefits for Basic Restorative Care. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

*** The maximum amount the Plan will pay for Benefits during the calendar year.

Covered Services

Dental Services described in this section are covered when such services are:

- Necessary
- Provided by or under the direction of a Dentist or other appropriate provider as specifically described
- The least costly, clinically accepted treatment; and
- Not excluded or limited as described in the 'Exclusions and Limitations' section of this document.

Covered Dental Services are subject to satisfaction of the Annual Deductible, Coinsurance, and any applicable limitations.

Description of Covered Service	PPO Dentist Plan Pays	Premier Dentist Plan Pays	Non-participating Dentist* Plan Pays
Class I Benefits			
Diagnostic and Preventive Services Includes charges for dental exams, cleanings, fluoride, and space maintainers. (Limitations may apply)	Covered in full.	Covered in full.	Covered in full.

Description of Covered Service	PPO Dentist Plan Pays	Premier Dentist Plan Pays	Non-participating Dentist* Plan Pays
Emergency Palliative Treatment Treatment to temporarily relieve pain.	Covered in full.	Covered in full.	Covered in full.
Sealants Prevents decay of permanent teeth.	Covered in full.	Covered in full.	Covered in full.
Brush Biopsy Detects oral cancer.	Covered in full.	Covered in full.	Covered in full.
Radiographs / X-Rays	Covered in full.	Covered in full.	Covered in full.
Class II Benefits			
Minor Restorative Services Includes fillings.	80%	80%	80%
Periodontic Services To treat gum disease including periodontal maintenance cleanings.	80%	80%	80%
Endodontic Services Includes root canals.	80%	80%	80%
Oral Surgery Services Extractions and dental surgery.	80%	80%	80%
Other Basic Services Miscellaneous Services	80%	80%	80%
Class III Benefits			
Relines and Repairs (to bridges and dentures).	50%	50%	50%
Major Restorative Services Includes crowns.	50%	50%	50%

Description of Covered Service	PPO Dentist Plan Pays	Premier Dentist Plan Pays	Non-participating Dentist* Plan Pays
Prosthodontic Services Includes bridges and dentures.	50%	50%	50%
Implants Endosteal implants to replace missing teeth.	50%	50%	50%
Occlusal Guards Appliance for bruxism or grinding of teeth. Covered under certain circumstances and subject to dental review when appropriate (see Exclusions)	50%	50%	50%

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of the Claims Administrator's Nonparticipating Dentist Fee that will be paid for those services. This Nonparticipating Dentist Fee may be less than what your Dentist charges, which means that you will be responsible for the difference.

All Covered Services and Benefits are subject to the conditions, exclusions, limitations, terms and provisions of this Summary Plan Description and Plan Document, including any attachments and Amendments.

Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of this Summary Plan Description and Plan Document.

Exclusions and Limitations

This section indicates items which are excluded and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services. This list of exclusions is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services.

Exclusions

The Claims Administrator will make no payment for the following services. All charges for the following services will be your responsibility (though your payment obligation may be paid by insurance or some other arrangement for which you are eligible):

- Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Benefits or services that are available from any government agency, political subdivision, community agency, foundation, or similar entity. This provision does not apply to any programs provided under Title XIX Social Security Act; that is, Medicaid.

- Services, as determined by the Claims Administrator, for correction of congenital or developmental malformations, cosmetic surgery, or dentistry for aesthetic reasons.

- Services or appliances started before a person became eligible under this Plan.

- Prescription drugs (except intramuscular injectable antibiotics), medicaments/solutions, premedications, and relative analgesia.

- General anesthesia and/or intravenous sedation for restorative dentistry or for surgical procedures, unless Medically Necessary.

- Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.

- Charges for hospitalization, laboratory tests, and histopathological examinations.

- Charges for failure to keep a scheduled visit with the Dentist.

- Services, as determined by the Claims Administrator, for which no valid dental need can be demonstrated, that are specialized techniques, or that are investigational in nature.

- Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the scope of his or her license.

- Those benefits excluded by the policies and procedures of the Claims Administrator, including the processing policies.

- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.

- Services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.

- Services that are covered under a hospital, surgical/medical, or prescription drug program.
- Services that are not within the classes of benefits that have been selected and that are not in the contract.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc).
- Space maintainers for maintaining space due to premature loss of anterior primary teeth.
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
- Veneers.
- Prefabricated crowns used as final restorations on permanent teeth.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, or erosion; or for periodontal splinting.
- Paste-type root canal fillings on permanent teeth.
- Replacement, repair, relines, or adjustments of occlusal guards.
- Chemical curettage.
- Certain Prosthodontic services (Class III Benefits):
    - Services associated with overdentures.
    - Metal bases on removable prostheses.
    - The replacement of teeth beyond the normal complement of teeth.
    - Personalization/characterization of any service or appliance.
    - Temporary appliances.
    - Posterior bridges in conjunction with partial dentures in the same arch.
    - Precision attachments or stress breakers.

    - Specialized implant surgical techniques, including a radiographic/surgical implant index.

    - Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).

- Orthodontic services are not a covered service

The Claims Administrator will make no payment for the following services. Participating Dentists cannot charge you for these services. All charges from Nonparticipating Dentists for the following services will be your responsibility:

- The completion of claim forms.

- Consultations, when performed in conjunction with examinations/evaluations or diagnostic procedures.

- Local anesthesia.

- Acid etching, cement bases, cavity liners, and bases or temporary fillings.

- Infection control.

- Temporary crowns.

- Gingivectomy as an aid to the placement of a restoration.

- The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.

- Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.

- Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the emergency condition.

- Post-operative X-rays, when done following any completed service or procedure.

- Periodontal charting.

- Pins and/or preformed posts, when done with core buildups for crowns, onlays, or inlays.

- A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage

of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

- A pulpotomy on a permanent tooth, except on a tooth with an open apex.
- A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
- Retreatment of a root canal by the same Dentist or dental office within 24 months of the original root canal treatment.
- A prophylaxis or full mouth debridement, when done on the same day as scaling and root planning or periodontal maintenance.
- An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
- Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
- Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

Limitations

The benefits for the following services are limited as follows. All charges for services that exceed these limitations will be your responsibility. All time limitations are measured from the last date of service in any Delta Dental record or, at the request of your group, any dental plan record:

- Bitewing X-rays are payable twice per calendar year. Full mouth X-rays (which include bitewing X-rays) are payable once in any three-year period. A panographic X-ray (including bitewings) is considered a full mouth X-ray.
- Prophylaxes, including periodontal maintenance procedures, and routine oral examinations/evaluations are payable twice in a calendar year, regardless of the dentist's specialty.
- Preventive fluoride treatments are payable twice per calendar year for people up to age 19.
- Space maintainers are payable once per lifetime for people up to age 19.
- Sealants are payable once per tooth per three-year period for the occlusal surface of first and second permanent molars up to age 14. The surface must be free from decay and restorations.

- Cast restorations (including jackets, inlays, crowns, and onlays) and associated procedures (such as core buildups and post substructures) on the same tooth are payable once in any five-year period.

- Crowns, inlays or onlays are payable only for extensive loss of tooth structure due to caries and/or fracture.

- Individual crowns over implants are payable at the prosthodontic benefit level.

- Porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.

- An interim partial denture is a benefit only for the replacement of permanent anterior teeth during the healing period or for people up to age 17 for missing permanent anterior teeth.

- Prosthodontic (Class III) benefit limitations:

    - One complete upper and one complete lower denture are benefits once in any five-year period for any person.
    - A removable partial denture, implant, or fixed bridge for any person can be covered once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    - Fixed bridges and removable cast partial dentures are not payable for people under age 16.
    - A reline or the complete replacement of denture base material is limited to once in any three-year period per appliance.
    - Implant removal is payable once per lifetime per tooth or area.
    - Implant maintenance is payable once per calendar year.

- The Claims Administrator's obligation for payment of benefits ends on the last day of the month in which coverage is terminated. However, the Claims Administrator will make payment for Covered Services provided on or before the termination date, as long as it receives a claim for those services within one year of the date of service.

- When services in progress are interrupted and completed later by another Dentist, the Claims Administrator will review the claim to determine the amount of payment, if any, to each Dentist.

- Care terminated due to the death of an Eligible Person will be paid to the limit of the Claims Administrator's liability for the services completed or in progress.

- Optional treatment: If you select a more expensive service than is customarily provided or for which the Claims Administrator does not determine a valid dental need is shown, the Claims Administrator can make an allowance based on the fee for the customarily provided service. You are responsible for the difference in cost.

For example, if a tooth can be satisfactorily restored with an amalgam (silver) restoration and you choose to have the tooth restored with a more costly procedure, such as a composite resin (white) restoration, the Plan will pay only the amount that it would have paid to restore the tooth with amalgam.

Listed below are some other examples of common optional services. Remember, you are responsible for the difference in cost for any optional treatment.

- Porcelain fused to metal and porcelain crowns on posterior teeth – the Plan will pay only the applicable amount that it would have paid for a full metal crown.
- Overdentures – the Plan will pay only the applicable amount that it would have paid for a conventional denture.
- Porcelain/ceramic onlays – the Plan will pay only the applicable amount that it would have paid for a metallic onlay.
- Soft relines – the Plan will pay only the applicable amount that it would have paid for a conventional reline.
- All-porcelain/ceramic bridges – the Plan will pay only the applicable amount that it would have paid for a conventional fixed bridge.

- Maximum Payment: The maximum benefit payable in any one benefit year will be limited to the amount specified in the Schedule of Benefits.

- If a Plan Deductible amount is specified in the Schedule of Benefits, the Claims Administrator will not be obligated to pay for, in whole or in part, any services to which the Deductible applies until the Plan Deductible amount is met.

- Processing policies may limit treatment.

The Claims Administrator will make no payment for services that exceed the following limitations. Participating Dentists cannot charge you for these services. All charges from Nonparticipating Dentists for services that exceed these limitations will be your responsibility:

- Amalgam and composite resin restorations by the same Dentist or dental office are payable once within a 24-month period, regardless of the number or combination of restorations placed on a surface.

- Core buildups and other substructures are benefits only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.

- Recementation of a crown, onlay, inlay, space maintainer, or bridge by the same Dentist or dental office within six months of the seating date.

- Retention pins are benefits once in a 24-month period. Only one substructure per tooth is a benefit.

- Frenulectomy and fenuloplasty are Covered Services.

- Benefits for root planing by the same Dentist or dental office are payable once in any two-year period.

- Periodontal surgery, by the same Dentist or dental office is payable once in any three-year period.

- A complete occlusal adjustment is a benefit once in a five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year period. A limited occlusal adjustment is not a benefit more than three times in a five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

- Tissue conditioning is not a benefit more than twice per arch in 36 months.

- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.

- Processing policies may limit treatment.

Termination of Coverage

You may terminate your coverage under this Plan at any time. Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving dental treatment on that date.

If you would like to drop coverage for yourself or your Dependents you must notify the Benefits office in writing by the 7th of the month preceding the month in which you wish to terminate coverage. For example, you must notify the Benefits Office by May 7th to terminate coverage effective June 1st. Otherwise, the change will be effective as soon as administratively practicable after receipt by your Benefits Office of your written request for termination of coverage.

When your coverage ends, the Claims Administrator will still pay claims for Covered Dental Services that you received before your coverage ended. However, once your coverage ends, the Claims Administrator will not provide Benefits for dental services that you receive for dental conditions that occurred before your coverage ended, even if the underlying condition occurred before your coverage ended.

For all Participants and Enrolled Dependents: Late Payment or Non-Payment of Premiums:

In the event that premiums are not paid within 31 days after becoming due, coverage will automatically be terminated retroactive to the last day of the month for which premiums were paid. Coverage due to nonpayment of premiums will not be reinstated.

Retired Participants

Except as provided otherwise in the Plan or law, your coverage under the Plan automatically terminates at 11:59 PM on the earliest of the following dates:

- The last day of the month in which the Participant ceases to be an Eligible Person
- The last day of the month for which the Participant has paid any required contributions for the cost of coverage under the Plan
- The last day of the month in which, in the opinion of the Plan Administrator, the Participant and/or the Enrolled Dependent of the Participant intentionally furnished incomplete or incorrect information to Battelle, the Plan Administrator or the Claims Administrator for the purpose of effecting coverage under the Plan. Such a determination by the Plan Administrator will prohibit future participation in any self-insured dental plan sponsored by Battelle; or
- The Effective Date that the Plan is discontinued or amended to terminate applicable eligibility of coverage.

Participants on Long-Term Disability

Except as provided otherwise in the Plan or law, your coverage under the Plan due to disability automatically terminates at 11:59 PM on the earliest of the following dates:

- The last day of the month in which the Participant ceases to be an Eligible Person
- The last day of the month for which the Participant has paid any required contributions for the cost of coverage under the Plan
- The last day of the month as of which the long-term disability benefits from the PNNL LTD Plan terminate
- The last day of the month in which, in the opinion of the Plan Administrator, the Participant and/or the Enrolled Dependent of the Participant intentionally furnished incomplete or incorrect information to Battelle, the Plan Administrator or the Claims Administrator for the purpose of effecting coverage under the Plan. Such a determination by the Plan Administrator will prohibit future participation in any self-insured dental plan sponsored by Battelle; or
- The Effective Date that the Plan is discontinued or amended to terminate applicable eligibility of coverage.

Enrolled Dependents

Except as provided otherwise in the Plan or law, coverage for Enrolled Dependents automatically terminates at 11:59 PM on the earliest of the following dates:

- The last day of the month in which the Dependent ceases to qualify as a Dependent under the Plan
- The date the Participant's coverage terminates
- The last day of the month for which the Participant has paid any required contribution for the cost of Dependent coverage

- The date applicable Dependent coverage is discontinued under the Plan, or
- The Effective Date that the Plan is discontinued or amended to terminate applicable eligibility or coverage.

Loss of Dependent Status

A former Spouse/Registered Partner is not eligible for coverage as a Dependent under the Plan. Eligibility for a Participant's former Spouse/Registered Partner ends as of the last day of the month in which the divorce between the Participant and Spouse/Registered Partner is final.

A Child is no longer eligible for coverage as a Dependent as of the end of the month in which he or she:

- Ceases to meet the requirements to qualify as a Dependent as defined under the Plan
- Becomes employed as a full-time employee (other than as a seasonal or temporary employee as determined by the Plan Administrator)
- Ceases to meet the requirements to qualify as a dependent for federal income tax purposes
- Becomes eligible for coverage under a Battelle sponsored dental Plan as an employee
- Ceases to qualify as a Disabled Dependent;
- Gets married, or
- Reaches age 23.

If any of your Enrolled Dependents loses eligibility as described above, you must notify the Benefits Office within 31 days of the loss of Dependent status. If you do not notify the Benefits Office within 31 days of the loss of Dependent status, coverage will retroactively terminate as described above once notification has been received. However, no right to continue coverage after the loss of Dependent status is obtained because of failure to notify the Benefits Office. Continuation of coverage after loss of eligibility is permitted only as required by COBRA.

If your coverage is retroactively terminated, you will be liable for all claims after the date coverage ends. If the retroactive termination reduces the monthly contribution you would have been required to pay after the termination and this results in an overpayment of contributions to the Plan, the overage will be used to offset your liability for the claims that were paid by the Plan after the termination date. If you have not incurred any claims, the overpaid premiums will be reimbursed to you.

Dependent status will not be affected for a Dependent that is otherwise eligible to be claimed as a Dependent for federal income tax purposes, but for a court order mandating that a party other than the Participant may take the federal income tax deduction.

Other Events Ending Your Coverage

When any of the following happen, the Plan will provide written notice to the Participant or to the Enrolled Dependent that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	Fraud or misrepresentation, or because the Participant or Dependent knowingly gave the Plan, the Plan Administrator or the Claims Administrator false material information. Examples include false information relating to another person's eligibility or status as a Dependent as well as permitting an unauthorized person to use your Identification Card or using another person's Identification Card. Your coverage may be retroactively terminated for fraud or any intentional misrepresentation of a material fact.
Failure to Pay	You failed to pay a required contribution. Your coverage may be terminated retroactively for a failure to make a required contribution.

Death of a Participant

Upon the death of the Participant, an Enrolled Dependent who is a surviving Spouse/Registered Partner may continue coverage by timely payment of the applicable premiums until the earliest of the date of:

- Death
- Remarriage
- Employment by Battelle or a controlled group member as a salaried staff member; or
- The Plan is discontinued or amended to terminate applicable eligibility or coverage.

An Enrolled Dependent other than a surviving Spouse may continue coverage after the Participant's death by timely payment of the applicable premiums until the earliest of the last day of the month following:

- Loss of eligibility as a Dependent (other than for lack of primary support by the Participant)
- Death of both parents covered by the Plan
- Death of the Dependent
- Employment by Battelle or a controlled group member as a salaried staff member; or
- The Plan is discontinued or amended to terminate applicable eligibility or coverage.

Payment of Dental Expenses after Death

Any dental expense Benefits that remain unpaid at the Participant's death may be paid directly to the provider of dental care being reimbursed or to any of the following, at the Claims Administrator's option: surviving Spouse, mother, father, child or children, brothers or sisters, or to the executors or

administrators of the estate of the Participant. Any payment under this paragraph discharges the Plan and Battelle from all further liability to the extent of the payment made.

Federal Continuation of Coverage (COBRA)

Under Federal law, Battelle is required to offer qualified beneficiaries the opportunity for a temporary extension of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as defined in the 'Definitions' section of this document, in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you and your Enrolled Dependents, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law.

Much of the language in this section comes from the federal law that governs continuation coverage. You should call the Benefits Office if you have questions about your right to continue coverage.

Qualifying Events for an Enrolled Dependent Who Is the Spouse/Registered Partner of a Participant

If you are the Spouse/Registered Partner of a Participant, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- The Participant dies
- The Participant becomes entitled to Medicare benefits (under Part A, Part B, or both)
- The termination of the Participant's employment (for reasons other than gross misconduct) or reduction in the Participant's hours of employment; or
- You become divorced or legally separated from the Participant.

If you are a Spouse/Registered Partner of a Participant, and your coverage is dropped by the Participant during open enrollment in anticipation of divorce, you will become a qualified beneficiary on the date of the divorce or dissolution.

Qualifying Events for an Enrolled Dependent Other Than Spouse/Registered Partner

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-Participant dies
- The parent-Participant becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The termination of the parent- Participant's employment (for reasons other than gross misconduct) or reduction in the parent- Participant's hours of employment; or
- The Child stops being eligible for coverage under the Plan as a Dependent.

Qualified Beneficiary Responsibility

The Participant or Enrolled Dependent has the responsibility to inform the Plan Administrator of a death, enrollment in Medicare, divorce, legal separation, or ceasing to qualify as a Dependent of the

Participant under the Plan. This notification must be made within 60 days from whichever date is later: the date of the qualifying event or the date that coverage terminates. To determine when an individual ceases to qualify as a Dependent under the Plan see the 'Loss of Dependent Status' section of this document.

If your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary.

Please send your notification to the following address:

Battelle Memorial Institute
Attn: Cobra Coordinator
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350

Employer Responsibility

Once the Plan Administrator is notified that a qualifying event has occurred, the Plan Administrator will notify covered individuals (also known as qualified beneficiaries) by mail of their right to elect continuation coverage.

If a qualified beneficiary does elect to continue coverage and pays the applicable contribution, then Battelle is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the Plan to similarly-situated Participants and Enrolled Dependents. If coverage is changed or modified for similarly situated Participants and Enrolled Dependents, continuation coverage may be similarly changed and/or modified

How to Elect COBRA Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Parents may elect COBRA continuation coverage on behalf of their children.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. The Plan does not allow for an extension of this maximum period. If a qualified beneficiary does not elect continuation coverage within this period, all rights to elect continuation coverage will end. After you elect COBRA coverage, you will then have an additional 45 days to pay the cost of your COBRA coverage retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a Participant in the Plan under COBRA, you have the right to change your coverage election during annual Open Enrollment.

Length of Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Participant, the Participant's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months from the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the Participant's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse/Registered Partner and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. This extension may be available to the Spouse/Registered Partner and any Dependent children receiving continuation coverage if the Participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse/Registered Partner or Dependent Child to lose coverage under the Eligible Employer's health Plan had the first qualifying event not occurred.

Eligibility and Premiums

You must be covered under the Plan at the time of a qualifying event in order to be eligible to elect continuation coverage. The Plan Administrator reserves the right to verify eligibility and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary may have to pay all of the applicable contribution plus a 2% administration charge for continuation coverage. These contributions may be adjusted in the future if the applicable contribution amount changes. The initial contribution is due within 45 days after the date of election and must include payment for all months necessary to bring your coverage to the current month. Thereafter, contributions are due the first day of the month for that month's coverage. There is a grace period of 30 days for the regularly scheduled monthly contributions. This is the maximum

grace period under the Plan, as the Plan does not provide for an extension beyond what is required by law.

When COBRA Ends

The law allows continuation coverage that has been elected and paid for to be terminated prior to the maximum continuation period for any of the following reasons:

- If you, or your Enrolled Dependent, have obtained coverage under any other group dental plan since your initial election of COBRA coverage, you are ineligible to continue to elect COBRA benefits under a Battelle-sponsored plan unless your other plan contains a pre-existing condition clause which affects you or a covered Dependent (this does not apply to children under age 23). In that case, COBRA is the primary coverage for claims for the pre-existing condition only and is a secondary payor for all other claims. Also, claims are to be submitted to the new carrier first and then, after consideration/denial, to your COBRA carrier. The COBRA office must be notified whenever you or a covered Dependent obtain other group coverage, and also, if such plan has a pre-existing condition limitation.
- You or your covered Dependent becomes eligible for Medicare after electing COBRA
- The first required Premium is not paid within 45 days
- Any other monthly Premium is not paid within 30 days of its due date
- A qualified beneficiary notifies the Plan Administrator that he/she wishes to cancel continuation coverage
- The entire Plan ends and Battelle ceases to maintain any other group dental plan; or
- Coverage would otherwise terminate under the Plan as described in the beginning of this section.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Child Born to or Placed for Adoption with the Participant during COBRA Period

A child born to, adopted by or placed for adoption with a Participant during a period of continuation coverage is considered a qualified beneficiary provided that, where the Participant is a qualified beneficiary, the Participant has elected continuation coverage for himself or herself. The Participant or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable Plan eligibility requirements (for example, regarding age). The Participant or a family member must notify the Plan Administrator within 31 days of the birth, adoption or placement for adoption to enroll the child in COBRA, and COBRA coverage will last as long as it lasts for other family members of the Participant. If the Participant or family member fails to notify the Plan Administrator in a timely fashion, then the Participant will NOT be offered the option to elect COBRA coverage for the child.

Alternate Recipient under Qualified Medical Child Support Order

Additionally, a child of a Covered Employee who is receiving benefits under a Group Health Care Plan pursuant to a Qualified Medical Child Support Order received by the Plan Administrator during

the Covered Employee's period of employment is entitled to the same rights under COBRA as a Dependent Child, regardless of whether that child would otherwise be considered a Dependent.

Address Changes

In order to ensure that you receive information properly and efficiently, please contact the COBRA Coordinator with any address changes as soon as possible. Failure on your part to do so may result in delayed notification and loss of continuation coverage options.

Workers' Compensation

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Other Government Programs

Except insofar as applicable law would require the Plan to be the primary payor, the benefits under the Plan shall not duplicate any benefits to which Covered Persons are entitled, or for which they are eligible under any other governmental program. To the extent the Plan has duplicated such benefits, all sums payable under such programs for services to Covered Persons shall be paid by or on behalf of the Covered Person to the Plan.

Coordination of Benefits

It is not intended that the Plan provide duplicate Benefits for services that are or should be covered by another plan. For this reason, if you or any members of your family are a Covered Person under this Plan and also another group plan, Benefits from this Plan will be coordinated with the benefits from the other plan to determine which plan is "primary" (i.e., pays benefits first). If the other plan is primary, the amount the Plan would otherwise pay is reduced to take into account payments made by the other plan, and/or amounts payable by the other plan, regardless of whether a claim for such benefits was made.

As a secondary payer, Battelle will apply any applicable Battelle Plan Annual Deductible and Coinsurance to the portion of Covered Dental Services not paid or payable by the primary plan. Only the amount applicable to this Plan as the secondary payer will be applied to this Plan's benefit limits.

Determination of Primary Coverage

The following rules apply in determining which plan is primary:

- When two plans apply and only one has a coordination of benefits provision, the plan without a coordination of benefits provision is primary.

- Where two plans apply and both plans have coordination of benefits provisions, the plan which covers a person as an employee will be considered primary.

- Where a Dependent Child's parents are divorced or legally separated and there is not a QMCSO, a plan which covers a person as a Dependent Child will be primary or secondary based on the birthday of the parents. The plan of the parent with a birthday (month and day, not year) which occurs earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. Where there is a QMCSO, the plan primarily responsible for providing benefits to a Dependent under a QMCSO will be primary.

- Where coverage under both an automobile insurance policy and this Plan apply, the automobile insurance policy will be the primary payer and this Plan will be the secondary payer.

In the event that the preceding rules do not establish the order of payment, the plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other plan except as follows:

- A plan covering an individual as a laid-off or retired employee or as the Dependent of such an individual will be secondary to a plan covering such individual as other than a laid-off or retired employee.

Coordination of Benefits Methodology

Coordination of Benefits is administered using a non-duplication methodology as follows: 100% of the total allowable expense is considered and claims are coordinated so that a maximum of 100% of the allowable expense may be covered. The secondary plan determines its normal liability and pays the **lesser of** (a) the allowable expenses minus the primary plan's payment, or, (b) its normal liability. Usually, the allowable expense minus the primary plan's payment equals the Participant's liability under the primary plan (e.g. Deductible, Coinsurance).

Overpayments

If the Plan pays Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if either of the following apply:

- All or some of the expenses that should have been paid by the Covered Person and were not paid by the Covered Person or did not legally have to be paid by the Covered Person; or
- All or some of the payment the Plan made exceeded the Benefits under the Plan.

The refund equals the amount the Plan paid in excess of the amount the Plan should have paid. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested as a condition of participation in the Plan.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future Benefits that are payable under the

Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits.

Subrogation and Right of Reimbursement

The Plan is governed by a Federal law called the Employee Retirement Income Security Act of 1974 ("ERISA"). Under ERISA, Plan fiduciaries have a duty to maximize reimbursements from Covered Persons, including exercise of subrogation and the right of reimbursement. "Subrogation" means the Plan's right to pursue your claims for charges paid by the Plan, against another person, entity or organization, and/or your or their insurer. The "Right of Reimbursement" means repayment to the Plan from a judgment, settlement or other type of recovery for benefits that the Plan advanced toward your benefits. The Plan's subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the Plan has advanced, or will advance, benefits and any costs and fees associated with the enforcement of its rights under the Plan.

You must repay the Plan from any recovery related to the benefits advanced by the Plan, whether by lawsuit, settlement or otherwise. The Plan's right of subrogation and reimbursement applies to all types of recoveries, including (but not limited to) insurance payments even if it is from your own insurance, reimbursements, cash payments and monies paid by way of judgment, settlement, or to reflect charges covered by the Plan. This right of subrogation and reimbursement also applies when you are entitled to recover under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Condition of Participation

As a condition of participating in the Plan, you must recognize the Plan's right to subrogation and reimbursement. Except for claims paid by another Battelle sponsored medical or dental plan, these rights provide the Plan with first priority over <u>any</u> proceeds (regardless of whether such funds fully or partially compensate you for your losses) paid by or on behalf of any party or any insurance company to you relative to an injury or sickness for which benefits are advanced by the Plan, including a priority over any claim for attorney fees, or other costs and expenses. The Plans' right to reimbursement shall not be reduced under any common fund or similar claims or theories. In other words, the make-whole doctrine shall not apply. You shall timely inform the Plan of any settlement offers. As an additional condition of participation, you agree to hold in a Plan accessible trust for the Plan's benefit under these subrogation provisions any and all proceeds of a settlement, arbitration award or judgment.

Assignment of Rights

Accepting payments advanced under the Plan automatically assigns to the Plan any rights you may have to recover payments for those expenses from any party and any insurer. This subrogation right allows the Plan to pursue any claim which, in the opinion of the Plan Administrator, you may have against any party and/or any insurer, whether or not you choose to pursue that claim.

Equitable Lien

The Plan shall automatically have a first priority equitable lien to the extent the Plan paid benefits

from any party or insurance company on any amount recovered by you. This equitable lien shall remain in effect until the Plan is repaid in full. Battelle and the Plan Administrator reserve the right to reduce any future benefit payments for you until the obligation to reimburse the Plan is satisfied. You shall execute any documents necessary to secure this right.

Requirement of Cooperation

When in the opinion of the Plan Administrator, a right of subrogation and/or reimbursement exists, you will be required to execute and deliver a Subrogation/Right of Reimbursement Agreement in the form prescribed by the Plan. You shall also respond to questionnaires, requests for information and documents as well as do whatever else is needed to secure the Plan's right of subrogation/right of reimbursement. Claims related to the Injury or Sickness may be suspended until the Subrogation/Right of Reimbursement Agreement and other forms provided by the Plan Administrator have been properly completed, signed and returned. In addition, you agree to do nothing to prejudice or diminish the right of the Plan to subrogate or receive reimbursement. You agree not to accept any settlement that does not fully compensate or reimburse the Plan without first acquiring the Plan's written approval of such settlement.

Attorney's Fees

The Plan shall not share the costs of, or pay any part of, the attorney's fees incurred in obtaining any recovery against the person, entity or organization causing the injury or sickness, or its insurer. Additionally, the Plan reserves the right to recover reasonable attorney fees from you that are incurred while enforcing its right to subrogation and reimbursement.

Future Expenses

Once repayment is made to the Plan, the Plan shall not have any further obligation to pay expenses related to the incident up to the total gross amount of recovery.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by the Plan or the Plan's designees, including the Claims Administrator, in accordance with the terms of the Plan.

Unclaimed Funds

If a benefit payment or an administrative expense check is not cashed within a reasonable period of time, as determined by the Plan Administrator, the check shall be voided and restored to the trust or other account from which payment was made. However, if the payee later makes a proper claim to the Plan for the amount, it shall be paid by Battelle to the payee in accordance with the terms of the Plan.

Indemnification

Battelle or the Plan may indemnify, through insurance or otherwise, any one or more of the fiduciaries with respect to the Plan against any claims, losses, expenses, damages, or liabilities arising out of the performance (or failure of performance) of their responsibilities under the Plan.

Governing Law

The Plan shall be construed in accordance with the laws of the State of Ohio, except where such laws are superseded by ERISA or the Internal Revenue Code in which case ERISA or the Internal Revenue Code shall control.

Invalidity of Certain Provisions

In the event any provisions of the Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan and the Plan shall be construed and enforced as if such illegal and invalid provisions had never been inserted herein.

Limitation of Action

If you want to bring a legal action against us, the Plan or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us, the Plan or the Claims Administrator.

You cannot bring any legal action against us, the Plan or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this document. After completing that process, if you want to bring a legal action against us, the Plan or the Claims Administrator you must do so within three years of the date you are notified of the Plan's final decision on your appeal or you lose any rights to bring such an action against us, the Plan or the Claims Administrator.

Circumstances beyond the Control of the Plan

In the event of circumstances not within the control of the Claims Administrator or Eligible Employer, including, but not limited to: a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Claims Administrator, disability of a significant part of a Network provider's personnel or similar causes, or the rendering of dental care services provided by the Plan is delayed or rendered impractical, the Claims Administrator shall make a good-faith effort to arrange for an alternative method of administering benefits. In such event, the Claims Administrator and Network providers shall administer and render services under the Plan insofar as practical, and according to their best judgment; but the Claims Administrator and Network providers shall incur no liability or obligation for delay, or failure to administer or arrange for services if such failure or delay is caused by such an event.

Protected Health Information under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Privacy Regulations issued under HIPAA, contain provisions designed to protect the privacy of certain individually identifiable health information. A complete description of your rights under HIPAA will be found in the Plan's privacy notice, which will be distributed to you upon enrollment and will be available from the Plan Administrator.

The Plan and the Plan Sponsor will not use or further disclose health information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and Plan administration functions, or as otherwise permitted or required by law. The Plan will not, without authorization, use or disclose protected health information for employment related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor except as permitted between plans that are part of an Organized Health Care Arrangement under HIPAA's privacy rule.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated. The Plan's privacy notice will provide a greater description of your rights and the Plan's obligations under the HIPAA privacy rule.

Policies and Procedures

The Claims Administrator, on behalf of the Eligible Employer, may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of the Plan with which a Covered Person shall comply.

Administrative Services

Battelle may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. Battelle is not required to give you prior notice of any such change, nor is it required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Waiver

No agent or other person, except an authorized officer of the Eligible Employer, has authority to waive any conditions or restrictions of the Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Claims Procedures

How to Obtain Benefits

When your care is rendered by a Network Provider, you are not required to file a claim. Network Providers are responsible for submitting a claim for payment directly to the Claims Administrator; however, a Covered Person is responsible for any Coinsurance at the time of service. Therefore, provisions below regarding "Filing a Claim for Out-Of-Network Benefits" and "Required Information" do not apply, unless the claim was not filed by the provider.

For services received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Unless your provider submits claims on your behalf, you must file the claim. Claims must contain all of the information required, as described below.

Filing a Claim for Out-Of-Network Benefits

When you receive Covered Dental Services from a Non-Network Provider, you are responsible for requesting payment from the Plan through the Claims Administrator. Unless your provider submits claims on your behalf, you must file the claim. Claims must contain all of the information required, as described below.

You may file a claim for payment of Covered Dental Services for you or your Enrolled Dependent. Claim forms are available from Benefits office, on the Benefits Homepage, or from the Claims Administrator. Claim forms include instructions for filing a claim. Submit completed claim forms to the Claims Administrator at the claims submittal address found in the Introduction. **Do not return the form to Battelle.** You should contact the Claims Administrator with any questions or for further information.

Benefits are generally paid to you, but can be paid to your provider if you complete the authorization section of the claim form and assignment of benefits is allowed in your state. You will receive an Explanation of Benefits (EOB) showing the amount paid and how the benefit payment was determined.

You must submit a request for payment of Benefits within 12 months after the Dental Service was performed. Delta Dental will make no payment for dental services if a claim for those services has not been received by Delta Dental within 12 months after the dental services were completed.

If a Non-Network Provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to the Plan within the required period, Benefits for that Dental Service will be denied.

If a Participant provides written authorization to allow direct payment to a provider and it is allowed in your state, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Participant. The Plan will not reimburse third parties who have purchased or been assigned Benefits by providers.

Required Information for Claims Submission

When you request payment of Benefits from the Plan, you must provide the Plan with all of the following information:

- Participant's name and address.
- The patient's name, birth date and relationship to the Participant.
- The member number (Employee's Social Security number or alternate identification number obtained from the Claims Administrator)
- Plan (Client) number 1033
- The name and address of the provider of the service(s)
- A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other Dental Services rendered before the charge was incurred for the claim
- Radiographs, lab or hospital reports
- Casts, molds or study models
- Itemized bill which includes the ADA codes or description of each charge
- The date the dental disease began
- A statement indicating that you are, or you are not, enrolled for coverage under any other dental or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, the Plan will make a benefit determination as set forth below. Benefits will be paid to you if the provider is a Non-Network Provider in any of the Claims Administrator's programs.

Post-Service Claims

"Post-Service Claims" are claims that are filed for payment of Benefits after dental care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within a reasonable period of time, not to exceed 30 days after receipt of the claim. The Claims Administrator may extend this 30-day period by 15 days if the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Plan and properly notifies you of the extension prior to the expiration of the initial 30-day period. The extension notice shall include the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is requested because the Plan needs additional information from you, you will be notified of the needed information within the initial 30-day period. Once notified of the extension, you have 45 days to provide the requested information to the Claims Administrator. The Claims Administrator, within 15 days after receiving the requested information shall notify you of its decision. If you do not provide the requested information to the Claims Administrator within the 45-day period, your claim will be denied and you will be notified of this denial within 15 days after the expiration of the 45-day period.

Pre-Service Claims

"Pre-Service Claims" or "Pre-determinations" are recommended for claims that exceed $200 for which you and your Dentist require notification or prior approval for determination of dental care for full Benefits. Predetermination is not a prerequisite to payment, but it allows claims to be processed more efficiently and allows you and your provider to know what services will be covered before you receive them. Because the amount of your Benefits is not conditioned on a Predetermination decision by the Claims Administrator, all claims under this Plan are Post-Service Claims.

Concurrent Care Claims

If you have been approved for a course of treatment and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen or extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, if your claim is denied (in whole or in part), you can seek a review of that decision before the course of treatment is scheduled to terminate.

Explanation of Benefits

After you receive dental care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement sent by the Claims Administrator to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any); and
- General information about your Appeals rights and information regarding the right to bring an action after the Appeals process.

Covered Person's Cooperation

Each Covered Person shall complete and submit to the Claims Administrator such authorizations, consents, releases, assignments and other documents as may be requested by the Claims Administrator, in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Covered Person who fails to cooperate will be responsible for any charge for services.

Authorized Representative

You or your authorized representative may file a claim or submit an appeal of an adverse benefit determination under the Plan. If you wish to designate a representative for this purpose, you should contact your Benefits Office or contact the Claims Administrator to request a form to fill out designating the person you wish to appoint as your representative. See the 'Important Information' section of this document for additional information.

While in some circumstances your Dentist may be treated as your authorized representative, generally only the person you have authorized on the last dated form filed with the Claims Administrator will be recognized. Once you have appointed an authorized representative, the Claims Administrator will communicate directly with your representative and will not inform you of the status of your claims. You will have to obtain that information from your representative. If you have not designated a representative, the Claims Administrator will communicate with you directly. An assignment of benefits by you to a dental care provider does not constitute designation of that provider as your authorized representative.

Assignment

The coverage and any Benefits under the Plan are not assignable by any Covered Person without the written consent of the Plan, except as provided above.

Information and Records

At times the Plan Administrator or the Claims Administrator may need additional information from you. You agree to furnish the Plan and/or the Claims Administrator with all information and proofs that the Plan Administrator or the Claims Administrator may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when it is requested it may cause the Plan to delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the Plan or the Claims Administrator with all information or copies of records relating to the services provided to you. The Plan Administrator or the Claims Administrator has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. The Plan Administrator and the Claims Administrator agree that such information and records will be considered confidential.

The Plan Administrator and the Claims Administrator have the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Plan, for appropriate review or quality assessment, or as the Plan Administrator or the Claims Administrator is required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, the Plan Administrator and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

For complete listings of your dental records or billing statements the Plan Administrator recommends that you contact your dental care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from the Plan, the Plan also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the Plan Administrator or the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, the Plan may require that a dentist or other appropriate provider of our choice examine you at the Plan's expense, when and so often as it may reasonably be required, and the Plan has the right to require an autopsy in case of death where it is not prohibited by law.

Appeals

Denial Notices

If your request is denied by the Claims Administrator, you shall timely receive a denial notice. The denial notice will provide:

- The specific reasons(s) for the denial, and, if applicable, either the specific internal rule, guideline, protocol or other similar criterion (if any) relied upon in making the denial, or a statement that a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request

- References to the part of the Plan on which the denial is based

- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary

- Appropriate information as to the steps to be taken if you desire to appeal the denial, including notice of applicable time limits, and a statement regarding your right to bring suit under Section 502(a) of ERISA following an adverse benefit determination on review

- If the denial is based on a Medical Necessity or Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for such denial that applies the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

What to Do First

If you receive notice of an adverse benefit determination, and if you think that the Plan incorrectly denied all or part of your claim, you can take the following steps:

First, you or your Dentist should contact the Claim Administrator's Customer Service department at their toll-free number, (800) 524-0149, and ask them to check the claim to make sure it was processed correctly. You may also mail your inquiry to the Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing, please enclose a copy of your Explanation of Benefits and describe the problem. Be sure to include your name, your telephone number, the date, and any information you would like considered about your claim. This inquiry is

not required and should not be considered a formal request for review of a denied claim. The Plan provides this opportunity for you to describe problems and submit information that might indicate that your claim was improperly denied and allow the Plan to correct this error quickly.

How to Appeal an Adverse Benefit Determination

Whether or not you have asked the Plan informally, as described above, to recheck its initial determination, you can submit your claim to a formal review through the Claims Appeal Procedure described here. To request a formal appeal of your claim, you must send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

You must include your name and address, the Eligible Person's Member ID number, the reason you believe your claim was wrongly denied, and any other information you believe supports your claim, and indicate in your letter that you are requesting a formal appeal of your claim. You also have the right to review your plan and any documents related to it. If you would like a record of your request and proof that it was received by the Plan, you should mail it certified mail, return receipt requested.

You or your authorized representative should seek a review as soon as possible, but you must file your appeal within 180 days of the date on which you receive your notice of the adverse benefit determination you are asking the Plan to review. If you are appealing an adverse determination of a Concurrent Care Claim, you will have to do so as soon as possible so that you may receive a decision on review before the course of treatment you are seeking to extend terminates.

The Dental Director or any other person(s) reviewing your claim will not be the same as, nor will they be subordinate to, the person(s) who initially decided your claim.

The Dental Director will grant no deference to the prior decision about your claim. Instead, he/she will assess the information, including any additional information that you have provided, as if he were deciding the claim for the first time.

The Dental Director will make his decision within 30 days of receiving your request for the review of Pre-Service Claims and within 60 days for Post-Service Claims. If your claim is denied on review (in whole or in part) you will be notified in writing. The notice of any adverse determination by the Dental Director will (a) inform you of the specific reason(s) for the denial, (b) list the pertinent Plan provision(s) on which the denial is based, (c) contain a description of any additional information or material that is needed to decide the claim and an explanation of why such information is needed, (d) reference any internal rule, guideline, or protocol that was relied on in making the decision on review and inform you that a copy can be obtained upon request at no charge, (e) contain a statement that you are entitled to receive, upon request and at no cost, reasonable access to and copies of the documents, records, and other information relevant to the Dental Director's decision to deny your claim (in whole or in part), and (f) contain a statement that you may seek to have your claim paid by bringing a civil action in court if it is denied again on appeal.

If the Dental Director's adverse determination is based on an assessment of medical or dental judgment or necessity, the notice of his adverse determination will explain the scientific or clinical judgment on which the determination was based or include a statement that a copy of the basis for that judgment can be obtained upon request at no charge. If the Dental Director consulted medical or dental experts in the appropriate specialty, the notice will include the name(s) of those expert(s).

What to Do if You are Denied on Appeal

If your claim is denied in whole or in part after you have completed this required Claims Appeal Procedure or the Plan fails to comply with any of the deadlines contained therein, you have the right to seek to have your claim paid by filing a civil action in court. However, you will not be able to do so unless you have completed the review described above. If you wish to file your claim in court, you must do so within three years of the date on which you receive notice of the final denial of your claim.

Benefit Determination

The Plan Administrator, Claims Administrator and any of their Delegates shall have the exclusive right to interpret and administer the Plan, and their decisions are conclusive and binding. Please note that Benefit decisions are based only on whether or not Benefits are available under the Plan for the proposed or incurred treatment or procedure. The determination as to whether the pending Dental Service is needed or appropriate is between you and your Dental Services provider.

How to Appeal a Denial of Eligibility or Enrollment

The Plan provides one level of appeal for eligibility or enrollment determinations. If you believe you should be covered under the Plan, but your eligibility or enrollment has been denied, then you may appeal that denial. You must mail a written request for a review (appeal) to the Plan Administrator within 180 days after your receipt of such denial. Your appeal should include an explanation of the reasons you believe you should be eligible to participate in the Plan. Your request will be provided a full and fair review by the Plan Administrator or its Delegate, and you will be notified of the decision in writing within a reasonable period of time, not to exceed 60 days after the Plan Administrator's receipt of your appeal. Your appeal for eligibility or enrollment may also qualify as a Pre-Service or Concurrent Care claim which may shorten the time period during which the Plan Administrator may respond.

Your written request for an **eligibility or enrollment appeal** should be sent to:

Plan Administrator
Battelle Memorial Institute
505 King Avenue
Columbus, OH 43201-2693

Definitions

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Active Employment/Actively at Work/Active Service: Active Employment, Actively at Work, and Active Service means you are working for an Eligible Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation on a day that is one of your Eligible Employer's scheduled workdays. You must be working in an eligible employment classification as described under the 'Eligible Groups' section of this document. Your work site must be your usual place of business, an alternative work site (including your home) at the direction of your manager, or a location to which your job requires you to travel. Normal paid time off (vacation) is considered Active Employment.

You are considered to be "Active" or in "Active Service" on a day that is not one of your Eligible Employers' scheduled workdays only if you performed in the customary manner all of the regular duties of your salaried employment on the next preceding scheduled workday.

Notwithstanding the foregoing, solely for purposes of eligibility for this Plan, you are considered to be in "Active Service" during the period for which you are eligible for continuation of medical and dental benefits under Battelle Operating Guide policy 140-4 "Involuntary Terminations- Severance Pay"

Alternate Recipient: Any child of a Participant who is recognized as having a right to enrollment in the Plan (with regard to such Participant) under a Qualified Medical Child Support Order (QMCSO).

Amendment: Any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Benefits: Your right to payment for Covered Dental Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including any applicable Amendments.

Benefit Period: The period of time that benefits for Covered Services are payable under the Plan. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Child: See **Dependent**

Claims Administrator: An organization or entity that the Plan Administrator contracts with to provide administrative and claims payment services under the Plan. The Claims Administrator is Delta Dental of Ohio ("Delta Dental"). The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance: Coinsurance is a fixed percentage that applies to certain Covered Dental Services after you meet the Annual Deductible. You are responsible for payment of any Coinsurance directly to the provider of the Dental Service at the time of the service or when billed by the provider.

Concurrent Care Claim: A Concurrent Claim arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Plan Participant requests extension of the course of treatment beyond that which the Plan has approved.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) : A federal law that requires employers to offer continued health insurance coverage to certain employees and their Dependents whose group health insurance has been terminated.

Covered Dental Service(s): A Dental Service or Dental Procedure is a Covered Dental Service when such services are:

- Necessary (see 'Necessary' in the glossary section of this document)
- Provided by or under the direction of a Dentist or other appropriate provider
- The least costly, clinically accepted treatment; and
- Not be excluded or limited as described in the 'Exclusions and Limitations' section of this document.

The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is covered under the Plan.

Covered Person: A Participant or Enrolled Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Eligible Employer and for whom Fee payment has been made. Covered Persons are sometimes called "you" or "your."

Deductible: The Annual Deductible is the amount you must pay each calendar year for Covered Dental Services before the Plan begins paying for Eligible Expenses. The Deductible does not apply to Diagnostic and Preventive services, Emergency Palliative Treatment, Brush Biopsy, X-rays (except for cephalometric films), and Sealants.

Delegate: The Claims Administrator and/or Plan Administrator may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on the Claims Administrator's or Plan Administrator's behalf.

Dental Service, Covered Service, or Dental Procedures: Dental care or treatment provided by a Dentist to a Covered Person while the Plan is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist: Any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dependent: Dependents of Participants who are eligible to be covered include your Spouse and your unmarried dependent children unless they are enrolled in a Battelle sponsored dental plan.

Dependent Child

A Dependent Child will be eligible for coverage under the Plan only until the end of the month in which he or she loses status as a Dependent under this Plan. A Dependent Child will not be covered after the end of the month in which he or she reaches age 23, except as provided below for individuals who are physically or mentally incapable of earning a living.

Your natural or adopted child, a child placed with you for adoption, a stepchild or any other child who resides in your home is considered your "child" for Plan purposes. However, a person is considered a "Dependent Child" under the Plan only if he or she can legally be claimed as your dependent for Federal income tax purposes.

A child may not be covered by more than one Participant for Plan purposes (e.g., for a child of married Participants).

During the period that an individual is a Registered Partner of a Participant under applicable state or local laws, the individual will be treated under the Plan as the Spouse of the Participant and eligible to be covered under the Plan as a Dependent.

Spouse

The (1) opposite sex Spouse of a Participant as recognized under the laws of the state in which the Participant is domiciled or (2) the same sex Spouse of a Participant as recognized under the laws of the state in which the Participant and Spouse were married.

Registered Partner

A Registered Partner is an individual who is a Registered Partner of a Participant under any state, city, county, or other political subdivision that offers a Partner registration. Registered Partners will be treated under the Plan as the Spouse of the Participant and eligible to be covered under the Plan as a Dependent. Notwithstanding the foregoing, the opposite sex Registered Partner of a Pacific Northwest Participant is excluded from the definition of Registered Partner and not eligible to participate in the Plan.

This definition of Spouse and Registered Partner shall only apply to this Plan and shall not affect any other benefit plan, or the treatment of the Registered Partner or Spouse under any state or federal laws, including ERISA and the Internal Revenue Code. The status of a Registered Partner will terminate as provided under applicable state or local laws and such termination shall be treated under the Plan as a divorce.

Disabled Dependent

Your unmarried child who is 23 years of age or over and who is mentally or physically incapable of self-sustaining employment may qualify for continued Dependent coverage. In order to qualify, the Dependent must meet all requirements for a Dependent under the Plan other than age, and must be primarily dependent upon you for support. Proof of mental or physical incapacity satisfactory to the Plan Administrator and evidence that the Dependent is primarily dependent upon you for support, must be submitted to the Plan Administrator within 31 days of failure to qualify as a Dependent solely because of attainment of age 23. Your Dependent must have been covered under this Plan as your Dependent when he or she attained age 23, and the incapacity must have commenced before the Dependent reached age 23. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

If you are a newly Eligible Person with a Disabled Dependent, within 31 days of your initial eligibility you must submit to the Plan Administrator proof as required above demonstrating your Dependent's continuing incapacity for self-sustaining employment beginning prior to age 23. In addition, you must provide evidence that your Dependent is primarily dependent on you for support and was covered by a group plan immediately prior to submitting your application for coverage under this Plan. If approved, coverage is retroactive to the date of eligibility. Evidence of ongoing/continued incapacity and your primary support is required at least annually.

The Participant must reimburse the Plan for any Benefits that the Plan pays for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom dental coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Plan is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The Plan Administrator may require a Participant to reimburse the Plan for any Benefits that the Plan pays for a Dependent at a time when the Dependent did not satisfy these conditions.

Disabled Dependent: See **Dependent**

Eligible Person: An Eligible Person refers to a retired or disabled staff member of an Eligible Employer who meets the eligibility rules. When an Eligible Person actually enrolls, that person is called a Participant. If both Spouses are Eligible Persons, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.

Classes of Persons Not Eligible: You and your Dependents are not eligible to participate in the Plan if you do not work for an Eligible Employer. In addition, an individual performing services for Battelle in any of the following categories (in a nondiscriminatory manner to all similarly situated employees) is not in a class of employees eligible to participate in this Plan:

a. Individuals treated as independent contractors
b. Contractor's employee

c. Union employee, except as provided in a collective bargaining agreement between the union and Battelle
d. Any member of the Board of Directors of Battelle who is not an eligible employee
e. Visiting professors
f. Spouse/Registered Partner performing military service
g. Interns and/or co-op students
h. Any person employed outside of the U.S. by a foreign-based subsidiary or division of Battelle
i. Temporary, leased, and seasonal employees.

Eligible Employer:

An "Eligible Employer" is Pacific Northwest Division of Battelle Memorial Institute.

An "Eligible Person" is a former staff member who meets all of the eligibility requirements in the Plan and immediately before retiring or becoming disabled was either:

- A staff member designated as a salaried employee of an Eligible Employer for payroll purposes; or
- A full-time hourly employee of an Eligible Employer who was covered by a collective bargaining agreement with an Eligible Employer.

When an Eligible Person actually enrolls, that person is called a Participant. If both Spouses are Eligible Persons, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both.

The Plan Administrator determines who is eligible to enroll under the Plan.

Eligible Expenses: Eligible Expenses are the amount that the Plan will pay for Benefits as determined by the Plan or its designee. In almost all cases the designee is the Claims Administrator. Eligible Expenses are based on either of the following:

- When Covered Dental Services are received from Network Providers, Eligible Expenses are the contracted fee(s) with that provider.

- When Covered Dental Services are received from Non-Network Providers, the Claims Administrator calculates Eligible Expenses based on industry standard competitive fees. The industry standard fees are determined from a database that contains charges for procedures all over the country. The Claims Administrator applies a formula that takes into account a number of factors including your geographic area, the complexity of the procedure, how frequently the procedure is performed, and the charges for similar procedures, to determine the industry standard charges for the procedure.

Eligible Expenses are determined solely in accordance with the Claim Administrator's reimbursement policy guidelines. The reimbursement policy guidelines are developed, in the Claim Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Dental Terminology (CDT), a publication of the American Dental Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by dental staff and outside dental consultants.
- Pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payer for the same services. In the event that a provider routinely waives Coinsurance, and/or annual Deductible for Benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Emergency: A serious dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent: A Dependent who is properly enrolled under the Plan.

Experimental/Investigative: Medical, dental, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time a determination regarding coverage in a particular case is made, are determined by the Claims Administrator to be Experimental/Investigative.

Medicare: Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary or Medically Necessary*:* Dental Services, Dental Procedures and supplies which are determined to be appropriate, and

- Necessary to meet the basic dental needs of the Covered Person
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service or Dental Procedure
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Claims Administrator
- Consistent with the diagnosis of the condition
- Required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- Demonstrated through prevailing peer-reviewed dental and/or dental literature to be either:
    - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
    - Safe with promising efficacy
        - For treating a life threatening dental disease or condition
        - In a clinically controlled research setting; and

- Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

For the purpose of this definition, the term "life threatening" is used to describe a dental disease or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Plan. The definition of Necessary used in this Plan relates only to coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network Provider/Participating Provider: A provider who has entered into a contractual agreement (or is otherwise engaged by the Claims Administrator) or with another organization which has an agreement with the Claims Administrator regarding payment for Covered Services and certain administration functions for the Networks associated with the Plan.

Non-Network Provider/Non-participating Provider: A provider who has not entered into a contractual agreement with Claims Administrator, on behalf of the Plan Administrator, or is not otherwise engaged by Claims Administrator, on behalf of the Plan Administrator, for any network associated with this Plan.

Participant: A retiree of an Eligible Employer who is properly enrolled under the Plan. The Eligible Person is the person (who is not a Dependent) on whose behalf the Plan is established.

Plan: The group dental benefit Plan provided by the Plan Sponsor and explained in this Summary Plan Description, which also serves as the legal Plan document.

Post-Service Claim: A claim that is filed for payment of Benefits after dental care has been received.

Premium(s): The periodic charges which are required to be paid by you and/or the Eligible Employer to maintain Benefits under the Plan.

Pre-Service or Pre-Determination Claim: An estimate of the costs of Covered Services to be provided. A Dentist may submit his or her treatment plan to the Claims Administrator before providing services. The Claims Administrator reviews the treatment plan and advises you and your Dentist of what services are covered by the Plan and what the Claims Administrator's payments may be. The Claims Administrator's payment for predetermined services depends on continued eligibility and the annual or lifetime maximum payments available under the Plan. You are not required to seek a predetermination. You will receive the same benefits under the Plan whether or not a predetermination is requested. Predetermination is merely a convenience so that you will know before the Dental Service is provided how much, if any, of the cost of that service is not covered under the plan. Since you may be responsible for any cost not covered under the Plan, this is likely to be useful information for you when deciding whether to incur those costs.

Registered Partner: See **Dependent**

Spouse: See **Dependent**

Summary Plan Description and Plan Document: This summary of the terms of your dental Benefits. This document is also the legal Plan document.

Years of Credited Service: Twelve consecutive months of Active Service in a salaried employment status after June 30,1976, at Battelle Memorial Institute (including the Pacific Northwest Division and Pacific Northwest National Laboratories). You lose your Years of Credited Service earned before a termination of employment unless you complete at least three consecutive Years of Credited Service in a continuous period of employment ending on your retirement date. Contact the Benefits Office if you have a question concerning your number of Years of Credited Service.

Years of Credited service include the period during which a Participant is eligible for and receives benefits from the BCO or PNNL LTD Plan.

Administrative and Contact Information

This section provides you with information about the administration of the Battelle Memorial Institute Dental Plan for BMI Retirees, commonly known as Delta Dental Plan for Retired PNNL Staff of Battelle Memorial Institute.

Plan Name

Battelle Memorial Institute Dental Plan for BMI Retirees

Plan Type

Welfare plan providing group dental benefits

Employer and Plan Sponsor

Battelle Memorial Institute
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350
Employer Identification Number (EIN)

31-4379427

Plan Number

540

Plan Year

January 1- December 31

Plan Administrator

Battelle Memorial Institute
Attn: Malesa A. Litteral, Esq.
505 King Avenue
Columbus, Ohio 43201-2693
(614) 424-6350

The Plan Administrator may designate other persons to carry out any of these responsibilities under the Plan, and the Plan Administrator and any other person so designated may employ one or more persons to render advice in regard to any responsibility they have under the Plan.

The Plan Administrator has the full and exclusive discretionary authority to:

- Interpret the Plan and to resolve all questions arising in the administration, interpretation and application of the Plan
- Interpret the other terms, conditions, limitations, and exclusions of the Plan
- Make factual determinations related to the Plan and its Benefits.

Benefits under this Plan will be paid only if the Plan Administrator or its Delegate decides in its discretion that the applicant is entitled to them.

The Plan Administrator or its Delegate shall establish the Plan's policies, interpretations, practices and procedures. The Plan Administrator or its Delegate has sole discretionary authority to determine eligibility for Benefits, to construe and interpret the terms of the Plan, to decide disputes that may arise relative to a Covered Person's rights and to decide questions of Plan interpretation and those of fact relating to the Plan. The determinations and interpretations of the Plan Administrator or its Delegate shall be conclusive and binding.

Upon challenge by a covered Participant, Dependent or other party, interpretations of Plan provisions, applications of the Plan to specific fact patterns and/or discretionary actions by the Plan Administrator and/or any other Plan fiduciaries shall be sustained unless the interpretation, application, or action in question was arbitrary and capricious.

In certain circumstances, for purposes of overall cost savings or efficiency, the Plan may, in the sole discretion of the Plan Administrator or its Delegate, offer Benefits for services that would otherwise not be Covered Dental Services. The fact that the Plan may do so in any particular case shall not in any way be deemed to require the Plan to do so in other similar cases.

Agent for Service of Legal Process

Battelle Memorial Institute
Attn: Daniel O. Cecil, Esq.
505 King Avenue
Columbus, OH 43201-2693

Service of legal process may also be made upon the Plan Administrator.

Plan Amendment Procedure

Battelle reserves the right at any time to change or terminate the coverage provided under the Plan and to change any amount charged for participating in the Plan at any time and without prior notice. Any such change or termination adopted by Battelle Memorial Institute shall be on its own behalf and on behalf of each participating Employer. "Participating Employer" is an Employer who has adopted the Plan with the written approval of Battelle Memorial Institute. The benefits to be provided under the Plan and the eligibility of employees members to participate in the Plan are to be determined from time to time under the then-effective provisions of the Plan instrument explaining the Plan.

Battelle has authority to amend or terminate the Plan at any time by its President or designated officer adopting a written instrument of Amendment or termination. In the event of Plan termination, any remaining assets of the trust funding the Plan will be used to provide Benefits due and payable under the terms of the Plan prior to being used for other permissible purposes under law. In no event will the assets be used for the benefit of the Employer. Any provision of the Plan which, on its Effective Date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

The Plan may be amended at any time to change or eliminate any or all Benefits under the Plan. The decision to amend or terminate the Plan belongs entirely to Battelle in its sole discretion. Benefits under this Plan do not accrue or vest to Participants or their Dependents regardless of the number of years of service with Battelle.

Statement of ERISA Rights

As a Participant in the Battelle Memorial Institute Dental Plan for BMI Retirees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance

contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Dental Plan Coverage

- Continue dental care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and Plan document on rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including Battelle, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights.

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, which is listed in your telephone directory.

You may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-275-7922. You may also visit EBSA's website on the Internet at http://www.dol.gov/ebsa.

As evidence of its adoption of the Battelle Memorial Institute Dental Plan for BMI Retirees, Battelle Memorial Institute has caused this instrument to be signed by its President or designated officer this 6th day of January, 2012, but effective as of January 1, 2011.

BATTELLE MEMORIAL INSTITUTE

By: _____Signature on file ____
Thomas Snowberger, Sr. V.P.
Human Resources