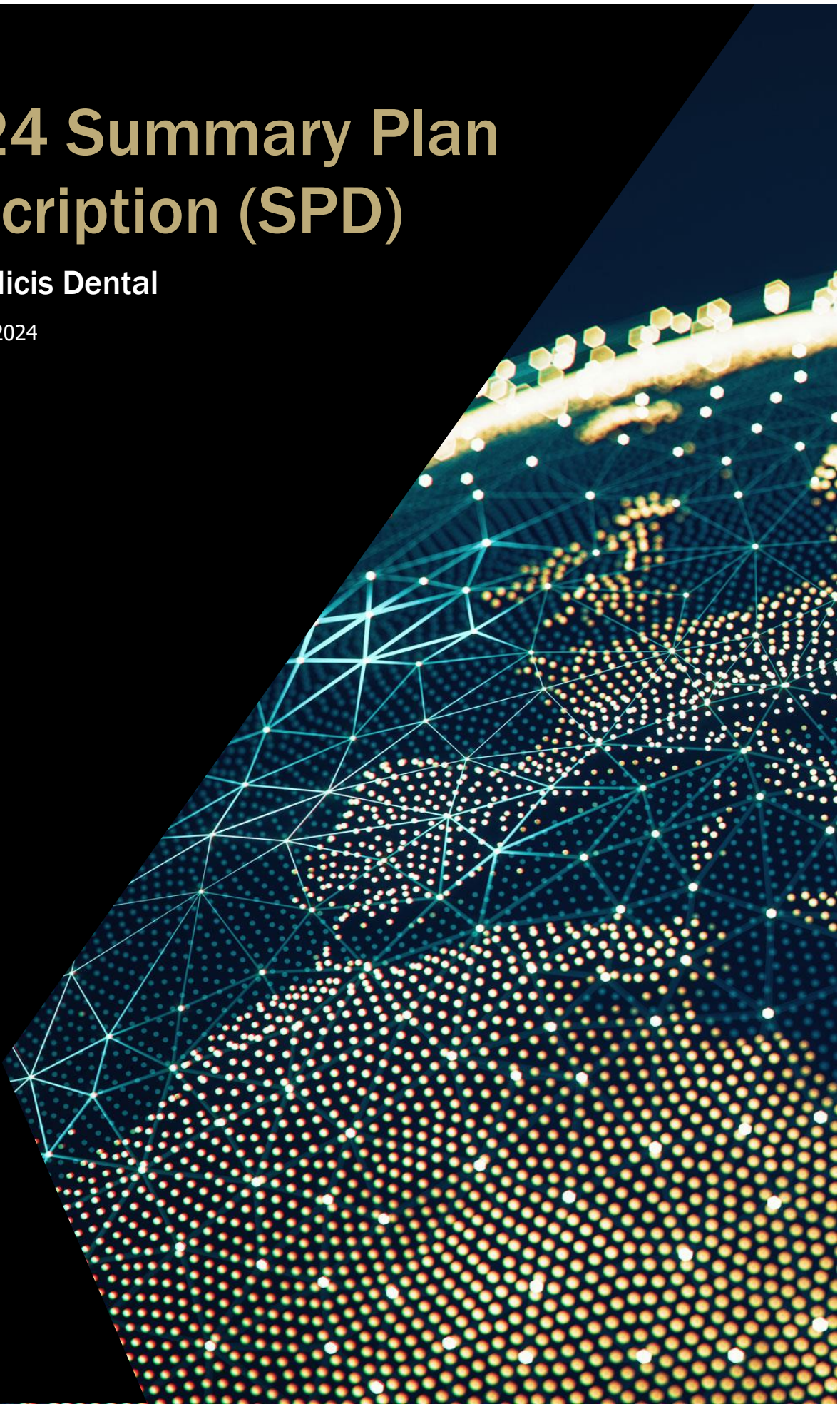
2024 Summary Plan Description (SPD)

for Publicis Dental

January 1, 2024



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Your Dental Coverage

Your Dental Coverage is an important part of your Publicis Connections Health and Group Benefits Program (the "Program" or the "Plan") sponsored by MMS USA Holdings, Inc. (the "Company"). That's why the ***Company*** offers eligible employees and their eligible dependents a choice of two dental coverage options, plus the flexibility to choose from a large network of dental providers.

This Summary Plan Description (SPD) together with the Administrative Information Summary Plan Description describes the basic features of your Dental Coverage, how it operates and how you can get the maximum advantage from it. These documents, together with other SPDs of Plan benefits, together with any plan-related document issued by an insurer, constitute a Plan Document and SPD. This document describes the Plan provisions as they exist as of January 1, 2024, while certain other information related to the Plan may be contained in the Administrative Information Summary Plan Description. If any statement, oral or written, made on behalf of the Plan disagrees with this Plan and SPD, as interpreted in the sole discretion of the Plan Administrator, the Plan Administrator's decision will govern.

Please note that the ***Company*** reserves the right to amend or terminate the plan at any time without notice. Participation in this plan does not constitute a contract of employment between you and the ***Company***.

Contact Delta Dental of New York (1-800-932-0783) if you need more information or if you have questions regarding your dental coverage.

Eligibility

Employee

You're eligible to participate in the Plan if you meet all of the following:

- You're a U.S.-based employee;
- You're a full-time or part-time employee working a minimum regular of at least 21 hours per week;
- You're an employee of a subsidiary of MMS USA Holdings, Inc. (the "***Company***") that has adopted the Program;
- You are not eligible for coverage under a dental plan sponsored by a union pursuant to an agreement or understanding between the Company and a union; and
- Your class of employees has not been excluded from this or a predecessor plan.

Please see your local HR Representative or the Publicis Re:Sources USA Benefits Department if you're unsure of whether your business unit participates in the Program or if you are a member of an eligible class of employees.

If an individual is not considered to be an "employee" for purposes of employment taxes and wage withholding, a subsequent determination by the employer, any governmental agency or a court that the individual is a common law employee, if such determination is applicable to prior years, will not have a retroactive effect for purposes of eligibility to participate in the Program.

Your Eligible Dependents

You may elect coverage for your eligible dependents. Your eligible dependents include your:

- **Spouse**, your spouse includes the individual to whom you are legally married (determined under federal law). Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.
- You may be required to provide (if requested) a copy of your marriage license.
- If you live in a state in which common law marriage is recognized and your "spouse" is your common law spouse under state law, you will be required to prove your marital relationship by providing a copy of a jointly filed federal tax return, or by completing the *Affidavit for Certification of Common Law Marriage* or by providing such other supporting documentation as may be requested by bswift (our benefits administration vendor) to verify eligibility.
- **Domestic Partners**, defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. If your domestic partnership is not registered with any state or local government agency, your same or opposite sex domestic partner also includes any individual that you have been residing within the same residence for at least six months.
- If you live in a jurisdiction that offers a domestic partner registry, you will be required to provide upon request, a copy of your domestic partner registration certificate to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage.

- If you do not live in a jurisdiction that offers a domestic partner registry or you have not registered, you will be required to complete and submit the *Affidavit for Certification of Domestic Partnership* to bswift (our benefits administration vendor) within 30 days of enrollment to verify eligibility for coverage in order for coverage to begin.
- **Note:** Domestic Partnerships are not recognized by the federal (and most states) government for tax purposes. This means that the value of your domestic partner's coverage will be imputed into your income, as required by tax law, if he or she is not otherwise your dependent under applicable tax law."
- **Dependent children**, include:
    - Your natural children or step-children;
    - Your legally adopted children;
    - Children placed with you for adoption;
    - Your foster children;
    - Any other children (including grandchildren) for whom you are the legal guardian (as determined by a court of competent jurisdiction); or
    - Any children of a *spouse or domestic partner* that must be covered as stipulated by a divorce decree.
    - Child(ren) of a domestic partner, not otherwise adopted by you.

Coverage for your dependent child continues (as long as your own coverage continues) until the end of the month in which he or she reaches age 26. If your dependent child is totally disabled as determined by the Program due to a mental or physical disability and he or she is continuously covered under the Program, coverage may continue beyond age 26 (provided the disability continues and you remain an eligible employee).

When you elect, or do not cancel, coverage for your spouse, domestic partner, or dependent child(ren), you are certifying that they continue to be eligible dependents under these rules. If your spouse, domestic partner, or dependent child(ren) is no longer eligible for coverage, you are expected to contact the Publicis Re:Sources USA Benefits Department as soon as possible to inform them of that fact.

From time to time, the Program will conduct eligibility audits. During an eligibility audit, you will be required to provide documentation substantiating your ***spouse***, ***domestic partner***, or dependent child(ren)'s eligibility in order for them to continue to receive benefits under the Program. The type of documentation that will be accepted will be determined by the ***Plan Administrator*** and communicated to you at the time of the audit.

Divorce Decree

The Program may be required to provide Dental Coverage for your child pursuant to the terms of a divorce decree. This coverage may apply even if you don't have legal custody of the child, the child isn't dependent on you for support and regardless of any enrollment season restrictions that might otherwise exist for dependent coverage. If the ***Company*** receives a valid divorce decree, the Plan may be required to allow you to enroll the dependent child, and if you don't enroll the dependent child, the custodial parent or state agency may enroll the affected child. Additionally, the ***Company*** may withhold from your wages any contributions required for such coverage.

A divorce decree may be either a National Medical Child Support Notice issued by a state child support agency, or an order or a judgment from a state court or administrative body directing the ***Company*** to cover a child under the Program. Federal law provides that a divorce decree must meet certain form and content requirements to be valid. The ***Company*** follows certain procedures to determine if a child support notice is "qualified." You may receive a copy of these procedures at no charge. If you have any questions, or would like a copy of the written procedures used to determine whether a divorce decree is valid, please contact the Publicis Re:Sources USA Benefits Department.

Dual Coverage

If your ***spouse*** or ***domestic partner*** works for a participating employer and is eligible for the Program, you have some unique choices to make.

You and your ***spouse*** or ***domestic partner*** both may choose "Employee Only" for medical, dental and vision coverage. Or, you may share your coverage if one of you elects ***spouse***/***domestic partner*** or family coverage.

If one employee chooses to cover his or her ***spouse*** or ***domestic partner*** under his or her plan, the other ***spouse*** (or ***domestic partner***) must elect "No Coverage." In addition, children may only be covered as dependents under one parent.

Enrollment

When You First Become Eligible

After your hire date, the Benefits team will upload your information into their system to get you started with enrolling for benefits. You will receive an email or mail notification from bswift—their benefits administrator—when you are able to enroll, and you won't be able to enroll before that notification. You have 45 days from your hire date to enroll. If you don't enroll within this 45-day period (your deadline date is listed on the enrollment worksheet that you receive at your home), you will only receive certain basic coverages provided by the ***Company***.

Here's what you need to do to enroll:

- Once you've been notified that you can enroll, review the Health and Group Benefits general information at PublicisConnections.com. Here you'll find everything you need regarding the basics of the benefit offerings.
- Once you are familiar with the plan options, which family members you can cover and how much you'll pay for your coverage during the upcoming ***plan year***, go to the **'View, Enroll, or Change Your Benefits'** to start enrolling. You can enroll 24 hours a day, seven days a week—except for regularly scheduled maintenance between midnight and 6:00 a.m. Eastern Time on Sundays.
- Remember to have the following information available for your online benefits enrollment:
  - The names, dates of birth and social security numbers of your ***spouse***, ***domestic partner*** and/or dependent child(ren) (if you are enrolling them for coverage). If your dependent child is age one or older, you need his or her social security number to enroll. If your dependent child does not have a social security number, please contact the Benefits Department immediately.
- Be sure to click the ***Submit*** button to save and submit your elections.
- After you submit your elections, a confirmation screen appears with your saved elections. Be sure to review and print this screen for your records. This screen is your confirmation statement. You will also receive an email that your elections have been submitted. **The email you receive only acknowledges you have gone out to the Publicis Connections website and made elections. It is not your confirmation statement**.
- After you review your confirmation statement as described above, you may need to correct your benefit elections. If this is the case, you can do so as many times as necessary within your 45-day election period by accessing the enrollment site and making changes.
- Visit the **Guides/Forms section** of the Publicis Connections website if you need to complete any necessary health and group benefits certifications or documents (i.e., domestic partner affidavit) to enroll. The online benefits enrollment prompts you if you need to submit a specific form.

The coverage you elect after you first become eligible continues through the remainder of the ***plan year***, unless you:

- Have a qualified change in status and decide to change your coverage; or satisfy the requirements for enrolling under HIPAA special enrollment periods;
- Cease to be eligible under the Program.

Annual Enrollment

Each fall, you can change your coverage for the following ***plan year***. You receive information and updates about your benefits under the Program so that you can make informed benefit elections during each annual enrollment period.

This information is generally available online on the Publicis Connections website (PublicisConnections.com), and includes:

- Important tips and information on how to enroll for the upcoming ***plan year***;
- The benefit options for which you're eligible for the upcoming ***plan year***; and
- Any changes that may have taken place since the last annual enrollment period.

You must enroll at annual enrollment unless notified otherwise by the ***Company***.

The coverages you elect during the annual enrollment period take effect the following January 1 (or the date you are considered ***actively at work***, whichever is later) and continue through the end of the ***plan year*** (unless you have a qualified change in status and decide to change your coverage or satisfy the requirements under HIPAA for a special enrollment period).

Enrollment Pursuant to a Divorce Decree

You, a custodial parent, or a state agency may enroll a dependent child pursuant to the terms of a valid divorce decree if the Program is required by law to provide Dental Coverage for your child pursuant to the terms of a valid divorce decree. A child who's eligible for coverage pursuant to a divorce decree may not enroll dependents for coverage under the Program.

Coverage under the Program is subject to payment of the required contribution unless, in the case of a child who's eligible for coverage pursuant to a divorce decree, payment of the required contribution is made by a state agency. The ***Company*** may withhold from your paycheck any required contributions for this coverage and send the contributions directly to the Program.

If You Don't Enroll

If you do not enroll when you are newly eligible or during the annual enrollment period, your benefit elections will not rollover into the following plan year and you will only have coverage in the Company-provided benefits such as Basic Life Insurance, Short-Term Disability, Basic Long-Term Disability, and the Employee Assistance Program. The only time your elected benefits will rollover into the next plan year is when the Company indicates that there will be a "passive" enrollment.

ID Cards

Once you enroll, you receive identification cards at your home address. Delta Dental does not require enrollees to use ID cards to receive treatment. Your dentist simply calls Delta Dental to confirm eligibility. Enrollees can also print ID cards from Delta Dental's website, deltadentalins.com.

When Coverage Begins

Coverage begins on the first of the month coinciding with or following your hire date or the date you first become eligible to participate in the plan. Your eligible dependents are covered on the same day that your coverage begins.

Paying For Your Coverage

Generally, you pay for your health (medical, dental, vision) coverage on a before-tax basis through payroll deductions each pay period. Using before-tax dollars reduces your taxable income for Federal, Social Security and (in most cases) state income taxes. In addition, your income isn't affected when determining your benefit levels for coverage under other ***Company***-sponsored Plans.

If you cover a ***domestic partner***, the portion of the premium that you pay that is attributable to your ***domestic partner***'s coverage is paid on an after-tax basis. In addition, you will have imputed income for the portion of the ***Company***-paid premium subsidy that is attributable to your ***domestic partner's*** coverage.

Using before-tax dollars can affect any Social Security benefits you may eventually receive. This is because you don't pay Social Security (FICA) taxes on before-tax dollars. For most people, the Social Security benefit reduction is just a few dollars a month. In addition, the reduction is typically more than offset by the tax savings you experience over the course of your career. If you have any concerns, or if you need additional information, contact your local Social Security Administration office.

You and the ***Company*** share the cost of your coverage. The percentage you pay is based on your location/employee group. Please contact the Benefits Department to determine the percentage of premium that you pay on a before-tax basis. Your annual enrollment materials also contain your cost for this coverage for the upcoming ***plan year***.

Changes in Coverage

Because of the tax advantages associated with certain benefits under the Program, the Internal Revenue Service (IRS) limits your ability to make changes to your benefits after initial enrollment to certain circumstances. These rules govern the types of changes that you may make during the ***plan year***.

In general, once you enroll for (or decline) coverage, your elections stay in effect for the entire ***plan year***. However, under certain circumstances, you may enroll for or change certain coverages during the year. For example, you may change your coverage if:

- You qualify for a special enrollment during the year under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- You experience a "qualified change in status" (see below) that affects you, your ***spouse's*** or your dependents' eligibility for benefits under the Program.
- The Program receives a divorce decree or other court order, judgment or decree that requires you to enroll a dependent.
- You, your ***spouse*** or your dependent qualifies for or loses Medicare or Medicaid coverage.
- You take a leave of absence under the Family and Medical Leave Act (FMLA) (however, you can't change coverage while you're on FMLA).

There are some additional circumstances under which you may make a mid-year change as described in this section.

Qualified Changes in Status

You may change certain benefit elections during the year if you experience a qualified change in status that results in a loss or gain of eligibility under the Program for yourself, your ***spouse***, your ***domestic partner*** or your eligible dependent children. Changes may be made to your Dental coverage as long as the changes are consistent, they correspond with the change in status and they follow the Plan's rules. For example, in the case of birth, adoption or placement for adoption, you may enroll your new dependent in your Dental Coverage.

A qualified change in status is any of the following circumstances that may affect coverage:

- You get divorced, legally separated or you have your marriage legally annulled.
- Your ***spouse*** or dependent dies.
- Your unmarried dependent becomes ineligible for coverage (e.g., he or she reaches the Program's eligibility age limit or gets married).
- You get married.
- You have a baby, adopt, or have a child placed with you for adoption.
- You, your ***spouse***, your ***domestic partner*** or your dependent experience a change in employment status (e.g., start or end employment, strike or lockout, begin or return from an unpaid leave of absence, change work sites or experience a change in employment that leads to a loss or gain of eligibility for coverage).

- You, your ***spouse***, your ***domestic partner***, or your dependent experiences a change in employment status that affects eligibility for coverage (e.g., change from part-time to full-time or vice versa).
- Your, your ***spouse's***, your ***domestic partner's*** or your dependent's home address changes (outside the network service area).
- You, your ***spouse***, your ***domestic partner*** or your dependent experiences a significant change in cost or coverage.

If you experience a qualified change in status and need to change your coverage during the ***plan year***, you must make your change online at PublicisConnections.com within 31 days of the event that necessitates the change. If you don't make the change in time, you can't make a coverage change until the next annual enrollment period, unless you once again meet one of the conditions for a mid-year change. Please note that you will be required to provide supporting documentation of your change. The change will be effective on the date of the qualifying event**.**

Special Enrollment Rules

Special enrollment rules apply under your Dental Coverage only due to a loss of other coverage or a need to enroll because of a new dependent's eligibility.

Special Enrollment Due to Loss of Other Coverage

You and your eligible dependents may enroll for Dental coverage (subject to certain conditions) if you waived your initial coverage at the time it was first offered under this Program because you (or your ***spouse*** or dependent) were covered under another plan or insurance policy. You and your dependents may enroll, provided your or your dependents' other coverage was:

- COBRA continuation coverage that has since been exhausted (In other words, you must continue COBRA coverage for the full duration of the COBRA coverage period); or
- Coverage (if not COBRA continuation coverage) that has since terminated due to a "loss of eligibility" or a loss of employer contributions.

  "Loss of eligibility" includes a loss of coverage due to:

  - Legal separation;
  - Divorce;
  - Death;
  - Termination of employment; or
  - Reduction in the number of hours of employment.

It doesn't include loss of coverage due to failure to timely pay required contributions or premiums or loss of coverage for cause (i.e., fraud or intentional misrepresentation).

You and your dependents must meet certain other requirements as well.

- **Required Length of Special Enrollment:** You and your dependents must enroll no later than 31 days from the day the other coverage was lost.
- **Effective Date of Coverage:** If you enroll within the 31-day period, coverage takes effect retroactive to the date coverage was lost.

Special Enrollment Due to New Dependent Eligibility

You and your eligible dependents may enroll for Dental coverage under the Program (subject to certain conditions) if you acquire a dependent through marriage, birth, adoption or placement for adoption. The conditions that apply are as follows:

- **Non-Enrolled Employee:** If you're eligible but haven't yet enrolled, you may enroll upon your marriage, or upon the birth, adoption or placement for adoption of your child.
- **Non-Enrolled *Spouse*:** If you're already enrolled, you may enroll your ***spouse*** at the time of his or her marriage to you. You may also enroll your ***spouse*** if you acquire a child through birth, adoption or placement for adoption.
- **New Dependents of an Enrolled Employee:** If you're already enrolled, you may enroll a child who becomes your eligible dependent as a result of marriage, birth, adoption or placement for adoption.
- **New Dependents/*Spouse* of a Non-Enrolled Employee:** If you're eligible but not enrolled, you may enroll an individual (***spouse*** or child) who becomes your eligible dependent as a result of marriage, birth, adoption or placement for adoption. However, you (the non-enrolled employee) must also be eligible to enroll, and actually enroll at the same time.
- **Required Length of Special Enrollment:** You and your dependents must enroll no later than 31 days from the date of marriage, birth, adoption, or placement for adoption.
- **Effective Date of Coverage:** Coverage takes effect retroactive to the date of the gain of dependent eligibility.

Additional Mid-Year Changes

You also may change your benefit elections during the year in the following circumstances.

Cost and Coverage Changes

You may be able to change your benefit elections if you, your ***spouse***, your ***domestic partner*** or your dependent experiences a significant change in cost of coverage. Under this rule, for example, if you switch from part-time to full-time employment or vice versa and as a result the cost of your benefits changes materially, you may be able to change your coverage. You may also be able to revoke your existing elections if your coverage is significantly curtailed (that is, if there is an overall reduction in coverage to all participants), or if a new benefit option is added or eliminated.

Changes to a Dependent's Plan

You may make a mid-year election change that is on account of, and corresponds to, changes made under the plan of your ***spouse***, former ***spouse*** or dependent's employer, or if the other plan has a different ***plan year***, or if the enrollment period is different from the one under this Program.

Automatic Changes

If the cost of your underlying coverage increases or decreases, the ***Company*** may automatically change the amount of your contribution that's withheld. Likewise, the ***Company*** may automatically change the amount of your deduction if it's required to do so by the terms of a

divorce decree or by the terms of another judgment, decree or order that requires the Program to provide coverage for your dependents.

Special Rule for Rehired Employees

If you terminate employment and are rehired within 30 days of your termination date, the benefit elections that were in effect on the date of your termination will be automatically reinstated. If you are rehired more than 30 days after the date of your termination, you will be allowed to make new benefit elections under the Program.

Procedure for Mid-Year Changes

You must request a change in your benefit elections within 31 days of the date of the change in status. If a change in status has been experienced, you may alter your benefit options to, among other things, add or drop a dependent, or add or drop coverage for yourself or your ***spouse***. Provided you notify the Program within the required time frames, any changes in your benefit options due to a permissible mid-year event will become effective:

- In the case of a dependent's birth, on the date of such birth;
- In the case of a dependent's adoption or placement for adoption, on the date of such adoption or placement for adoption; and
- For all other events, on the date of the qualifying event.

Note that coverage cannot be paid for retroactively on a pre-tax basis (although it can be retroactively effective) except for in the case of birth, adoption or placement for adoption.

If you experience one of these qualified changes in status, you may change your Dental, coverage. The changes must be consistent with and correspond to the change in status as well as follow Plan rules. For example, in the case of birth, adoption or placement for adoption, you may enroll your new dependent for dental coverage, but you can't drop your current coverage.

If you experience a qualified change in status and need to change your coverage, you must make the change online at PublicisConnections.com, or you must notify the Benefits Department and request assistance with the change. Your change must be made within 31 days (which includes the day the event occurred) of the event that causes the change. If you don't make the change in time, you can't make a coverage change until the next annual enrollment, unless you once again meet one of the conditions for a mid-year change. If requested, you may have to provide proof of your change in status.

Coordination of Benefits

If you or your dependents have coverage under another similar plan, your benefits under this Program coordinate with benefits outside the Program to help eliminate duplicate payments for the same services. This section highlights the coordination of benefits (COB) feature.

Coordination Plans

Certain types of plans normally coordinate benefits, including the following:

- Plans or coverage provided by an employer, union, trust or other similar sponsor.
- Other group health care plans or coverage that covers you or your dependents, including student coverage provided through a school above the high school level.
- Government benefit programs provided or required by law, including Medicare or Medicaid.
- Automobile insurance plans in the case of accidents.

These coordination provisions don't apply to individual or private insurance plans.

Any benefits to which you may be entitled will be considered for possible coordination (even if you don't request payment from them).

How Coordination Works With Other Group Plans

If you're covered by more than one group plan, one plan is primary. The primary plan pays benefits first without considering the other plans. Then — based on what the primary plan pays — the other plans may pay a benefit (if any).

If your coverage under the Plan is primary, the Plan pays benefits up to the limits described in this Summary Plan description.

If your coverage is secondary, the Plan pays the lesser of:

- The Plan's benefit; or
- The balance left after the primary plan pays benefits.

When combined, the benefits that the two coverages pay won't exceed 100% of the Allowed Amount.

Determining the Order of Payment

When benefits coordinate, the plans or coverage involved determine which pays benefits first (the primary), second (the secondary), etc. Here are the plan's guidelines for determining which is primary:

- If one plan has no Coordination-of-Benefits (COB) provision, it automatically is primary.
- The plan covering the person as the employee, rather than as a dependent, laid-off employee, terminated employee, COBRA Beneficiary or retired employee is primary and pays benefits first.
- If both parents' plans cover a dependent, the plans use the "Birthday Rule" to determine which parent's plan pays first. The plan of the parent whose birthday comes earlier in the calendar year is the primary plan, and the other parent's plan is secondary. If the other plan doesn't follow the Birthday Rule, then the rules of that plan determine the order of benefits.

In the case of a divorce or separation, the plan relies on the "Birthday Rule" to determine which parent's plan pays first. However, if there's a court order requiring a parent to take financial responsibility for health care coverage for the child, that parent's plan always is primary.

If a determination can't be made as to the order of payment, the plan that has covered the person longer is usually the primary plan.

Subrogation and Reimbursement

The Program may pay a benefit to you, or on behalf of you and/or your dependents in situations where another party was responsible for your or your dependent's illness, injury or other loss. (An example would be a personal injury caused by someone's negligence.) If this is the case, the Program has a right of subrogation as to any funds recovered. In other words, if you or your dependents accept benefits from the Program, you must reimburse the Program in full if you receive payment from any person, entity, organization or their insurers as a recovery for your illness or injury, no matter how that recovery is characterized (medical damages, lost wages, permanent injury damages, etc.).

The Program has the right to a full and complete subrogation of all payment it makes to or on behalf of you and/or your dependents—even if you and/or your dependents aren't or won't be fully compensated or made whole by the person or entity providing a recovery related to the injuries or damages. You and/or your dependents must fully cooperate with the Program so that it may exercise its right of subrogation. This may include (but isn't limited to) advising the ***Company*** that another party may be responsible for your medical expenses or allowing the Program to pursue legal actions and claims in the name of you and/or your dependents. You and/or your dependents must sign and deliver such documents as this Program or its agents reasonably request to protect this Program's rights of subrogation, equitable lien or constructive trust. You and your dependents must also provide any relevant information and take such actions as this Program or its agents reasonably request to assist this Program in making a full recovery of the reasonable value of benefits provided. You and/or your dependents must not do anything to prejudice the Program's rights of subrogation, equitable lien or constructive trust.

The Program has the right to a full and complete reimbursement from you and/or your dependents, and should be reimbursed for all payments made from any recovery you and/or your dependents obtain from any insurance company, responsible third party, entity or organization (even if you and/or your dependents have not or will not be fully compensated or made whole for the injuries). In order to secure the rights of the Program, you and/or your dependents hereby: (1) grant to this Program a first priority lien against the proceeds of any settlement, verdict or other amounts received by them or any attorney on behalf of the covered individual; (2) assign to this Program any benefits you and/or your dependents may have under any automobile policy or other coverage, to the extent of this Program's claim for repay; and (3) agree to the imposition of a constructive trust on the proceeds of any settlement, verdict or other amounts received by the covered individual.

In exercising its right of recovery through either subrogation or reimbursement, the Program isn't responsible for any fees, expenses, attorneys' fees or representatives' fees that you and/or your dependents may incur to obtain the funds needed to reimburse the Program or pay the Program's subrogation interest. The Program's subrogation claim is paid first out of any recovery obtained.

If a settlement is reached, you must reimburse (in full) the Medical, Dental or Disability benefits paid to you by the Program, before any other expenses are paid (including attorney's fees, up to

but not exceeding your settlement amount). If the settlement is less than the benefit paid, you must notify the ***Company*** before you agree to compromise the Program's right to recover the benefits it has advanced you.

If you refuse to reimburse the Program, the Program may recover from you by other means, including offsetting future benefit payments.

Continuation or Termination of Coverage

Your coverage will continue until the end of the month in which you end your employment or cease to be eligible to participate in the plan.

Your dependents' coverage will end on the last day of the month in which (whichever occurs first):

- Your coverage ends;
- You stop making contributions; or
- Your dependent no longer meets the eligibility requirements.

If You Die While Employed

If you die while you're still employed, your contributions for Dental Coverage end on the date death occurs. Your covered dependents are eligible to continue health care coverage under COBRA for 36 months.

If You Become Disabled

If you become disabled and are eligible to receive disability benefits under the STD program, coverage for you and your dependents in the appropriate benefit plans continues provided you continue to receive STD benefits.

If your disability continues and you start collecting long-term disability benefits from the LTD Plan, your active coverage will terminate at the end of the month in which your LTD benefits commence and you and your covered dependents are then eligible to continue coverage under COBRA.

If You Take a Leave of Absence

You may decide to take either an unpaid personal leave or an unpaid FMLA leave of absence.

- **Unpaid Personal Leave:** If you take an unpaid personal leave of absence for 30 days or less, coverage continues for you and your eligible dependents. However, you must submit payment for the full cost of the coverage.

  If your unpaid personal leave of absence is more than 30 days, coverage for you and your dependents ends the first of the month following your 30th day of leave. You and your dependents can continue health care coverage under COBRA. If you return to active employment for the ***Company***, you must reenroll for benefits upon your return.
- **Unpaid FMLA Leave:** If you decide to take an unpaid FMLA leave, coverage continues for you and your eligible dependents as if you were still an active employee. However, you must continue to submit payment for this coverage (at the active rate). You can select a core coverage of health, dental and vision, or you can continue all of your coverages. You may also decide to discontinue your coverage under the Plan.

Continuation of Coverage Under the Family and Medical Leave Act of 1993 (FMLA)

The ***Company*** continues your coverage under the plan during your period of FMLA leave just as if you were still employed. Continued coverage ends once you:

- Terminate employment; or
- Exhaust your approved period of FMLA leave, and don't return from your FMLA leave.

If your employment doesn't terminate during your leave, but you don't return to work once your leave ends, you can elect to continue health coverage under the COBRA continuation rules. Your COBRA continuation period begins on the last day of your FMLA leave.

If you're on an unpaid leave and fail to reimburse the ***Company***, the ***Company*** may recover the value of benefits or premiums paid to maintain your health coverage during your FMLA period of leave.

Continuation of Coverage Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you're absent from work because of your service in the ***uniformed services*** (including Reserve and National Guard duty), you may elect to continue health coverage for yourself and your eligible dependents under the provisions of USERRA. The period of coverage for you and your eligible dependents ends on the earlier of:

- The end of the 24-month period starting on the day your military leave of absence begins.
- The day after the day on which you're required but fail to contact your employer or return to work. Under USERRA, you must contact your employer regarding your return to work within different time periods—depending on the duration of your uniformed service:
  - **If your uniformed service is less than 31 days:** You're generally required to contact your employer regarding your return to work on the first full calendar day of the first full scheduled work period following your period of uniformed service. (Your period of uniformed service ends after you return from your place of service to your residence.)
  - **If your uniformed service is between 31 and 180 days:** You're generally required to contact your employer regarding your return to work within 14 days of your discharge.
  - **If your uniformed service is at least 181 days:** You're generally required to contact your employer regarding your return to work within 90 days of your discharge.

You may be required to pay all or a portion of the cost of your coverage:

- **If your military service is 31 days or less:** You're required to pay no more than your usual share of the cost for this period of coverage.
- **If your military service is more than 31 days:** You must pay the entire cost of the coverage (not to exceed 102% of the applicable premium similar to the manner in which the cost for COBRA continuation coverage is calculated).

You must also notify your HR Representative that you'll be absent from employment due to military service (unless you can't give notice because of military necessity or unless under all relevant circumstances, notice is impossible or unreasonable). You must also notify your HR Representative that you want to elect continuation coverage for yourself and/or your eligible dependents under the USERRA provisions.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires the Program to offer you and your dependents the opportunity to pay for a temporary extension of health care coverage in certain situations where your active employee coverage is lost. This section highlights your COBRA coverage.

When You and/or Your Dependents Elect COBRA

COBRA allows you and your dependents to continue the coverage that was in effect on the day that your active employee coverage would have ended. In other words, if you didn't have active coverage, you can't elect COBRA. If coverage under the Program changes while you're on COBRA, your coverage will also change. In addition, you'll have the same annual enrollment benefit choices as Program participants.

If you elect COBRA coverage, it takes effect on the date your coverage under the Program ended, and continues for up to 18 to 36 months (depending on your situation).

COBRA applies to the medical, dental, vision, EAP and Health Care Spending Account plans.

Snapshot of COBRA Continuation Coverage

Here's a snapshot of who's eligible for COBRA coverage continuation, under what circumstances, and how long COBRA coverage continuation lasts.

If:	Qualifying Event	Who's Eligible for COBRA Coverage	Duration of COBRA Coverage*
You	Become laid off	You and your dependents	18 months
	Have a reduction in hours	You and your dependents	18 months
	Terminate employment	You and your dependents	18 months
	Don't return from a leave of absence after six months	You and your dependents	18 months
	Begin collecting LTD Plan benefits.	You and your dependents	18 months**
	Become disabled within the first 60 days of COBRA continuation coverage	You and your dependents	29 months
	Die	Your dependents	36 months
	Become divorced or legally separated	Your dependents	36 months
	Become entitled to Medicare while on COBRA	Your dependents	Up to 36 months***
Your Dependent	Is no longer an eligible dependent (due to age limit, divorce or legal separation)	Your dependent	36 months
	Is no longer an eligible dependent because of your death	Your dependent	36 months
	Becomes disabled within the first 60 days of COBRA continuation coverage	You and your dependent	29 months

*Duration of coverage is from the date of the qualifying event.
**You may be eligible for an additional 11 months of COBRA due to an eligible disability.
***The 36-month coverage begins on the day you become eligible for Medicare.

The *COBRA* rights of you and your dependents will be fully detailed in a notice that will be sent to you in connection with your *COBRA* event within 14 days after the *Company* notifies bswift of the COBRA event.

Employee Loses Dental Plan Coverage

If you lose coverage because of a layoff, reduction in hours, you begin collecting LTD Plan benefits or terminate employment, COBRA continuation coverage is available to you and your dependents for up to 18 months from the date of the qualifying event, bswift notifies you and your dependents of your right to continue coverage when you experience a qualifying event. Such an event makes continuation of coverage available. You must then notify bswift (within 60 days of the later of the date you receive notice of your COBRA rights or the date the coverage is lost) of your decision to continue coverage. You can reach bswift by calling **1-866-365-2413**.

If you elect coverage within the 60-day period and pay the required premium, your coverage is retroactively reinstated. If you don't elect COBRA within the initial enrollment period, or if you don't pay the required premium in full, your coverage ends, and you won't be able to reenroll in the future.

Even if you decline COBRA, each of your eligible dependents has an independent right to elect or reject COBRA coverage. A parent or legal guardian can elect COBRA on behalf of a minor child.

If you or your covered dependent becomes disabled, as defined by Social Security, during the first 60 days of COBRA continuation coverage, the disabled beneficiary and each non-disabled COBRA beneficiary may extend the 18-month continuation period an additional 11 months, up to 29 months. For the 29-month continuation coverage period to apply, you must notify bswift at **1-866-365-2413** that you or your covered dependent is disabled within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage.

If, during the initial 18-month period, the Social Security Administration determines that you're no longer disabled, the 11-month extension doesn't apply. If your disability ends during the 11-month extension period, your COBRA coverage ends the first day of the month after 30 days have passed since the Social Security Administration's determination (provided the COBRA period doesn't exceed 29 months).

Dependent Loses Dental Plan Coverage

Your covered dependent has the right to continue his or her coverage for up to 36 months from the date of the qualifying event if he or she loses coverage because:

- You and your ***spouse*** become divorced or legally separated;
- He or she is no longer eligible for coverage under the Program (i.e., reaches the age limit);
- You become entitled to benefits under Medicare; or
- You die.

If any of the above situations occur, notify the *Company* within 31 days of the qualifying event by logging onto the Publicis Connections website (PublicisConnections.com) and following the appropriate prompts. The *Company* will then notify bswift, who will then

send out the COBRA rights notice. Failure to take appropriate action via the website may result in the loss of COBRA rights. bswift in turn notifies your dependent of his or her COBRA enrollment options. Your dependent must elect to continue coverage by notifying bswift within 60 days of the later of the date the benefits terminate due to the qualifying event or the date the dependent receives notice of his or her COBRA rights.

Newborn or Adopted Children

If during your COBRA continuation period, you have or adopt a child, you may elect COBRA for that child. Coverage for the newborn or adopted child continues for the remainder of your 18-month (or 29-month) continuation period, as a qualified COBRA beneficiary.

Cost of COBRA Coverage

If you elect COBRA continuation, you're responsible for paying the required premium. The cost is 102% (a 2% administrative cost is added to the actual cost of the coverage) of the total premium rate. These costs are reviewed annually and are subject to change. For benefits that are self-insured, the premium rate is based on actuarial data.

You or your dependents will be billed monthly for the coverage(s) you or your dependents elect. Payment is due by the first of the month for which you're buying coverage. If payment isn't received within 30 days of that date, the coverage will be cancelled. The first premium payable when you or a dependent initially elects COBRA coverage, however, is due within 45 days of the coverage election.

How to Apply for COBRA Coverage

To enroll in COBRA, contact bswift at **1-866-365-2413** or the Publicis Re:Sources USA Benefits Department.

If your home address changes while on COBRA, notify your HR Representative or the Publicis Re:Sources USA Benefits Department.

When COBRA Coverage Ends

COBRA continues until the earliest of the following:

- The end of the 18-month, 29-month or 36-month continuation period.
- The date the ***Company*** no longer provides health care coverage to any of its employees.
- The date a required premium for continuation of group coverage is due and not paid within the required time.
- After you elect COBRA continuation coverage, the date you and your dependents become entitled to Medicare or covered under another group health care plan (provided pre-existing condition exclusions or limitations under the new group health care plan don't apply).

Special continuation periods apply to retired participants and their dependents in the event of bankruptcy under Title 11 of the United States Code if the retired participant and his or her dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Retired participants may continue their coverage until their death. For a ***spouse***, surviving ***spouse*** or dependent child of the retired participant, coverage ends at the earlier of the qualified beneficiary's death, or 36 months past the date of the death of the retired participant.

How Your Dental Coverage Works

In this document you'll find a brief overview of your coverage options, as well as how the features of your dental coverage work.

About Your Coverage Options

Your dental coverage includes two coverage options: a Comprehensive PPO and a Basic PPO. The options differ in the types of services covered and annual maximums. Review the chart on the next page to determine these amounts for either coverage option.

With either option, you receive benefits whether or not you and/or your eligible dependents visit a ***Delta Dental PPO℠ or Delta Dental Premier® provider***. However, when you visit a ***PPO or Premier provider***, you have the opportunity to maximize your benefit with lower out-of-pocket expenses.

You choose a provider at the time of treatment; you don't have to pre-select a primary ***dentist***, nor do you need an ID card or referrals for specialty care. For more information on finding a participating ***dentist***, visit the benefits website (**PublicisConnections.com**) and link to the Delta Dental network.

General Information

You may choose from two dental coverage options: the Comprehensive PPO and the Basic PPO. Here's a snapshot of the benefits under each option.

Highlights	Delta Dental -- PPO Basic Dental Plan (Passive, no benefit steerage)	
	Preferred Benefits In-Network Provider (Delta Dental PPO or Delta Dental Premier)	**Non-Preferred Out-of-Network**
Plan Deductible (per calendar year -- applies to all expenses except Type A expenses reimbursed at 100%)	**Individual: $100** Family: $300	
Type A Expenses **(Diagnostic and Preventive)** (Cleanings, Oral Exams, Office Visits, Fluoride, X-rays and Space Maintainers, Sealants)	100% of applicable Allowed Amount, deductible waived	100% of applicable Allowed Amount, deductible waived
Type B Expenses **(Basic Restorative Care)** (Fillings, Periodontics, Simple Extractions, Endodontics, Restorations, Oral Surgery, Stainless Steel Crowns)	50% of applicable Allowed Amount, deductible applies	50% of applicable Allowed Amount, deductible applies
Type C Expenses **(Major Restorative Care)** (Crowns, Inlays, Onlays, Gold Fillings, Dentures, Bridgework, Crown-Lengthening & Core Build-Up)	No Coverage	No Coverage
Calendar Year Plan/Benefit Maximum (Integrated maximum for both In- and Out-of-Network Expenses)	$1,000 per covered member Diagnostic and Preventive services are exempt from the maximum	
Implants	No Coverage	
Orthodontics	No Coverage	
Orthodontic Lifetime Maximum	$0	
Orthodontia Eligibility	None	
Space Maintainer Eligibility	Employee and Dependents	
Fluoride Eligibility	Dependent Children to age 18	
Sealants Eligibility	Dependent Children to age 18	
Emergency benefit	Delta Dental enrollees and dependents are free to use any dentist anywhere. If a Delta Dental dentist is not available, out-of-network benefits may apply.	

Frequency of Exams, Cleanings and Bitewings	Two routine cleanings and exams per calendar year; bitewings once per calendar year. Two periodontal cleanings per calendar year.
Frequency for Sealants	Once every 3 years (for permanent molars only)
Frequency of Fluoride Treatment	One treatment in any 12 consecutive months for dependents under age 18
Frequency of full series of X-rays or a panoramic X-ray	Once every five years
Missing Tooth Exclusion	Does not apply
Alternate Course of Treatment	Applies
Predetermination of Benefits	Recommended for services over $300
Eligibility	All employees
Dependents Eligibility	Spouse, domestic partner, children from birth to the end of the month they reach 26
Employee Active at Work Dependent Non-Confinement Rules	Does not apply
Coordination of Benefits	Not to exceed allowed amount.
To locate a Delta Dental dentist near you: • Log onto Delta Dental's website: deltadentalins.com • Click on the **"Find a Dentist"** link • Select your plan option (Delta Dental PPO or Delta Dental Premier). • Enter options such as state and ZIP Code • Search for a dentist and link to a map with driving directions	**How you can save money:** You'll likely save: • Most if you go to a Delta Dental PPO dentist. • Some if you go to a Delta Dental Premier dentist. • Least if you go to a non-participating dentist.

Highlights	**Delta Dental -- PPO Comprehensive Dental Plan**	
	(Passive, no benefit steerage)	
	Preferred Benefits In-Network Provider	**Non-Preferred Out-of-Network**
	(Delta Dental PPO or Delta Dental Premier)	
Plan Deductible (per calendar year -- applies to all expenses except Type A expenses reimbursed at 100%)	**Individual: $50** Family: $150	

Type A Expenses **(Diagnostic and Preventive)** Cleanings, Oral Exams, Office Visits, Fluoride, X-rays and Space Maintainers, Sealants)	100% of applicable Allowed Amount, deductible waived	100% of applicable Allowed Amount, deductible waived
Type B Expenses **(Basic Restorative Care)** (Fillings; *Periodontics; Simple Extractions; *Endodontics; Emergency Palliative; Oral Surgery; Stainless Steel Crowns; Bridge, Crown, Inlay and Onlay Recementation)	80% of applicable Allowed Amount, deductible applies	80% of applicable Allowed Amount, deductible applies
Type C Expenses **(Major Restorative Care)** (Crowns, Inlays, Onlays, Gold Fillings, Dentures, Bridgework, Crown-Lengthening & Core Build-Up, General Anesthesia, IV Sedation)	50% of applicable Allowed Amount, deductible applies	50% of applicable Allowed Amount, deductible applies
Calendar Year Plan/Benefit Maximum (Integrated maximum for both In- and Out-of-Network Expenses)	$2,000 per covered member Diagnostic, Preventive and Orthodontic services are exempt from the maximum	
Implants	50% of applicable Allowed Amount, deductible applies	
Orthodontics	50% of applicable Allowed Amount, deductible applies	
Orthodontic Lifetime Maximum	$2,000	
Orthodontia Eligibility	Adults; Dependents to the end of the month they reach 26	
Space Maintainer Eligibility	Employee and Dependents	
Fluoride Eligibility	Dependent Children to age 18	
Sealants Eligibility	Dependent Children to age 18	
Emergency benefit	Delta Dental enrollees and dependents are free to use any dentist anywhere. If a Delta Dental dentist is not available, out-of-network benefits may apply.	
Frequency of Exams, Cleanings and Bitewings	Two routine cleanings and exams per calendar year; bitewings once per calendar year. Two periodontal cleanings per calendar year.	
Frequency for Sealants	Once every 3 years (for permanent molars only)	
Frequency of Fluoride Treatment	One treatment in any 12 consecutive months for dependents under age 18	
Frequency of full series of X-rays or a panoramic X-ray	Once every five years	
Missing Tooth Exclusion	Does not apply	
Alternate Course of Treatment	Applies	
Predetermination of Benefits	Recommended for services over $300	
Eligibility	All employees	

Dependents Eligibility	Spouse, domestic partner, children from birth to the end of the month they reach 26
Employee Active at Work Dependent Non-Confinement Rules	Does not apply
Coordination of Benefits	Not to exceed allowed amount
	*The following services are payable as Type C and will not be covered as a Type B expense: Osseous surgery and molar root canals.
To locate a Delta Dental dentist near you: • Log onto Delta Dental's website: deltadentalins.com • Click on the "Find a Dentist" link • Select your plan option (Delta Dental PPO or Delta Dental Premier). • Enter options such as state and ZIP Code • Search for a dentist and link to a map with driving directions	**How you can save money:** You'll likely save: • Most if you go to a Delta Dental PPO dentist. • Some if you go to a Delta Dental Premier dentist. • Least if you go to a non-participating dentist.

The Comprehensive Option provides full reimbursement for covered preventive/diagnostic services (including periodic exams, certain x-rays and cleanings) and pays a percentage of the cost of other covered services including basic (e.g. fillings, root canal therapy for anterior and bicuspids, periodontal treatment and extractions), major (e.g. crowns and dentures, crown-lengthening, core build-up, implants, molar root canal, osseous surgery, partial and full bone impactions) and ***orthodontia services*** (corrective dentistry for children and adults to the end of the month they reach age 26).

The Basic Option also offers full reimbursement for covered preventive/diagnostic services and covers a percentage of basic services, but major and ***orthodontia services*** are not covered.

Choosing Whom to Cover

In addition to selecting a coverage option, you need to decide whom to cover by selecting a coverage level. You can select from the following coverage levels:

- Employee Only;
- Employee Plus One; or
- Employee Plus Two or More.

How Benefits Are Paid

A deductible, coinsurance, and annual and lifetime maximums apply, depending on the type of care you receive. Here's a brief description of each feature.

Deductible

The deductible is the fixed dollar amount that you pay out of your pocket each year before you receive benefits. See the snapshot chart on the previous page to determine the deductible amount that applies. **Please note:** The deductible only applies to Basic, Major and Orthodontic coverages.

The individual deductible applies separately to each covered individual, and the family deductible applies collectively to all covered persons in the same family. Once two individuals in a family have met the family deductible, your remaining covered family members don't have to meet their individual deductible amounts for the rest of that year.

Coinsurance

This is the percentage of ***eligible expenses*** you're responsible for paying. Coinsurance percentages apply after any applicable deductibles. The coinsurance amount you pay depends on the type of service you receive. See the snapshot chart on the previous page for the coinsurance percentage paid for each type of ***eligible expense*** under your coverage option.

Please note: If you receive care from a non-participating ***dentist***, you're responsible for payment of the non-participating dentist's total fee, which may include amounts in addition to the Delta Dental payment amount and non-covered services.

Annual Maximums

Benefits are limited for each covered person during each calendar year. See the snapshot chart on the previous page for the annual maximums that apply for your coverage option. Preventive services are exempt from the annual maximum. Orthodontic expenses aren't included in this limit. A separate lifetime limit applies to orthodontic services for each person eligible for these benefits.

Orthodontic Lifetime Maximum

The individual lifetime maximum is the maximum amount paid for orthodontic expenses during the life of a covered individual. See the snapshot chart for the orthodontic lifetime maximum that applies under your coverage option.

The Delta Dental Networks

Payment for services is determined in accordance with the specific terms of your Dental Coverage or with the terms of Delta Dental's agreements with Delta Dental network dentists.

Payment for services performed for you by Participating Dentists who are Delta Dental PPO ("PPO") Dentists is calculated by Delta Dental on the basis of a reduced Maximum Plan Allowance ("reduced MPA") or the fee charged, whichever is less ("PPO Allowed Amount"). Participating Dentists who are Delta Dental PPO Dentists have agreed to accept the PPO Allowed Amount as full payment for services covered by the Contract.

Payment for services performed for you by Participating Dentists who are *not* Delta Dental PPO Dentists (Delta Dental Premier Dentists only) is calculated by Delta Dental on the basis of a Maximum Plan Allowance ("MPA") or the fee charged, whichever is less ("Delta Dental Premier Allowed Amount"). Participating Dentists who are Delta Dental Premier Dentists only have agreed to accept the Delta Dental Premier Allowed Amount as full payment for services covered by the Contract.

Delta Dental calculates its share of the PPO Allowed Amount or Delta Dental Premier Allowed Amount using the previously described Copayment Schedule ("Delta Dental Payment") and sends it to the Participating Dentist. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible ("Patient Payment"). If your Dentist is a Delta Dental PPO Dentist, the Patient Payment is generally the difference between the Delta Dental Payment and the PPO Allowed Amount – i.e., copayments, deductibles, charges where maximums have

been exceeded – and charges for services not covered by the Contract. If your Dentist is a Delta Dental Premier Dentist only, the Patient Payment is generally the difference between the Delta Dental Payment and the Delta Dental Premier Allowed Amount – i.e., copayments, deductibles, charges where maximums have been exceeded – and charges for services not covered by the Contract.

Payment for services performed for you by a Non-Participating Dentist is calculated by Delta Dental using a maximum fee level that may be higher than Delta Dental's Maximum Plan Allowance. Delta Dental pays its Delta Dental Payment to you. You are responsible for payment of the Non-Participating Dentist's total fee, which may include amounts in addition to the Delta Dental Payment amount and services not covered by the Contract.

To find a provider in your area, visit Delta Dental's through the link on the Publicis Connections website or at deltadentalins.com.

Pre-Determination of Benefits

If total charges for a treatment plan for you, your spouse or domestic partner, or a dependent child exceed an amount which Delta Dental establishes ($300), predetermination is recommended for approval of the charges for payment. The attending dentist is requested to submit the claim form in advance of performing services. Delta Dental will act promptly in returning a predetermination voucher to the attending dentist and the Subscriber to be treated with verification of eligibility, scope of benefits and definition of sixty (60) day period for completion of services.

If You Have Questions

If you have questions about what materials you need to supply, please contact Delta Dental at 1-800-932-0783. Also, please know that if you don't initially supply the appropriate verifying material for a complete review, Delta Dental will contact you and request specific additional verifying material.

Covered Dental Services

Benefits are paid up to the applicable ***Allowed Amount*** for ***eligible expenses*** that are ***necessary*** in terms of generally accepted dental standards. See the snapshot of your dental options to see how benefits are paid for each covered service under the two options.

Preventive Services

Benefits are paid for the following preventive services under the Basic and Comprehensive PPO coverage options:

Visits and X-Rays

- Office visit during regular office hours, for oral examination
  - Routine comprehensive or recall examination (limited to 2 visits every calendar year)
  - Problem-focused examination (limited to 2 visits every calendar year)
- Prophylaxis (cleaning) (limited to 2 treatments per year in addition to 2 periodontal cleanings)
- Topical application of fluoride (limited to one course of treatment per 12-month period and to children to age 18)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children to age 18)
- Bitewing x-rays (limited to one set per year)
- Complete x-ray series, including bitewings if ***necessary***, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing x-rays (limited to 1 set every 3 years)
- Periapical x-rays

Space Maintainers

(Includes all adjustments within six months after installation)

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)

Basic Services

Benefits are paid for the following basic services under the Basic and Comprehensive PPO coverage options:

Visits and Exams

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit

X-Ray and Pathology

- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue

Oral Surgery

- Extractions
  - Uncomplicated
  - Surgical removal of erupted tooth/root tip
- Impacted Teeth
  - Removal of tooth (soft tissue)
- Odontogenic Cysts and Neoplasms
  - Incision and drainage of abscess
  - Removal of odontogenic cyst or tumor
- Other Surgical Procedures
  - Alveoplasty, in conjunction with simple extractions – per quadrant
  - Alveoplasty, not in conjunction with extraction – per quadrant
  - Sialolithotomy: removal of salivary calculus
  - Closure of salivary fistula
  - Excision of hyperplastic tissue
  - Removal of exostosis
  - Closure of oral fistula or maxillary sinus
  - Sequestrectomy
  - Crown exposure to aid eruption (covered when done as a separate procedure with no other procedure)
  - Removal of foreign body from soft tissue
  - Frenectomy
  - Suture of soft tissue injury

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc.)
- Occlusal adjustment (other than with an appliance or by restoration)
- Root planing and scaling, per quadrant, limited to 4 separate quadrants every 2 years
- Gingivectomy (including post-surgical visits) per quadrant, limited to 1 per quadrant every 3 years
- Gingivectomy, treatment per tooth (fewer than 3 teeth), limited to 1 per site, every 3 years
- Gingival flap procedure, including root planing, per quadrant
- Periodontal maintenance procedures following surgical therapy (periodontal cleanings are limited to 2 per year in addition to 2 routine cleanings)

Endodontics

- Pulp capping
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root Canal Therapy, including ***necessary*** x-rays
  - Anterior
  - Bicuspid

Restorative Dentistry

Excludes inlays, crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in one surface will be considered as a single restoration.)

- Amalgam Restorations – Primary Teeth
- Amalgam Restorations – Permanent Teeth
- Resin Restorations
- Sedative Fillings (covered if not submitted on the same day as an endodontic procedure)
- Pins
  - Pin retention – per tooth, in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
  - Prefabricated stainless steel
  - Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge
- Occlusal guard (for bruxism only) limited to one every three years

Major Services

Benefits are paid for the following major services, under the Comprehensive PPO coverage option:

Oral Surgery

- Impacted Teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

Periodontics

- Osseous surgery (including post-surgical visits), per quadrant, limited to 1 per quadrant every 3 years

Endodontics

- Root Canal Therapy, including ***necessary*** x-rays
  - Molar

Restorative

Cast or processed restorations and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.

Replacement of crowns, dentures and bridges is a benefit once in 7 years.

- Inlays/Onlays – Metallic or Porcelain/Ceramic*
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Inlays/Onlays – Resin*
  - Inlay, one or more surfaces
  - Onlay, two or more surfaces
- Labial Veneers
  - Laminate-chairside
  - Resin laminate – laboratory
  - Porcelain laminate – laboratory
- Crowns
  - Resin
  - Resin with noble metal
  - Resin with base metal
  - Porcelain
  - Porcelain with noble metal
  - Porcelain with base metal
  - Base metal (full cast)
  - Noble metal (full cast)
  - Metallic (3/4 cast)
  - Clinical crown-lengthening
  - Core build-ups, including pins
- Post and core

* Porcelain, ceramic and resin inlays and onlays are considered optional. If porcelain, ceramic or resin inlays or onlays are provided, Delta Dental will pay the allowance for a porcelain/high noble inlay or onlay and the patient will be responsible for the additional cost.

Prosthodontics

- Bridge Abutments (see Inlays and Crowns)
- Pontics
  - Base metal (full cast)
  - Noble metal (full cast)

  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- Removable Bridge (unilateral)
  - One piece casting, chrome cobalt alloy clasp attachment (all types) per unit, including pontics
- Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within six months after installation. Fees for relines and rebases include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.)
  - Complete upper denture
  - Complete lower denture
  - Partial upper or lower, resin base (including any conventional clasps, rests and teeth)
  - Partial upper or lower, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
  - Stress breakers
  - Interim partial denture (stayplate), anterior only
  - Office reline
  - Laboratory reline
  - Special tissue conditioning, per denture
  - Rebase, per denture
  - Adjustment to denture more than six months after installation
- Full and Partial Denture Repairs
  - Broken dentures, no teeth involved
  - Repair cast framework
  - Replacing missing or broken teeth, each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only) limited to 1 every 3 years
- Implants

General Anesthesia and Intravenous Sedation

General anesthesia and IV sedation are benefitted with all covered oral surgery procedures and with select endodontic and periodontal surgeries.

Orthodontia

Benefits are paid for the following orthodontia services, only under the Comprehensive PPO coverage option:

- Comprehensive orthodontic treatment
- Interceptive orthodontic treatment
- Limited orthodontic treatment
- Post treatment stabilization
- Removable inhibiting appliance to correct thumb sucking
- Fixed or cemented inhibiting appliance to correct thumb sucking

Dental Expenses Not Covered

You receive benefits for many dental expenses, provided they're ***necessary*** in terms of generally accepted dental standards and appropriate to properly treat a dental condition. However, some limits and exclusions do apply. Covered Dental Expenses do not include and no benefits are payable for charges for:

- Any dental services and supplies which are covered in whole or in part:
  - under any other part of this Plan; or
  - under any other plan of group benefits provided by your employer.
- Those for services and supplies to diagnose or treat a disease or injury that is the result of:
  - an ***occupational disease***; or
  - an ***occupational injury***.
- Those for services not listed in the schedule as covered expenses; except as specifically provided.
- Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
- Those for:
  - dentures;
  - crowns;
  - inlays;
  - onlays;
  - bridgework; or

  other appliances or services used for the purpose of splinting, to alter vertical dimension to restore occlusion, or correcting attrition, abrasion or erosion.
- Those for any of the following services:
  - an appliance, or modification of one, if an impression for it was made before the person became a covered person;
  - a crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the person became a covered person;
  - root canal therapy, if the pulp chamber for it was opened before the person became a covered person.
- Those for services intended for treatment of any ***jaw joint disorder***; except as specifically provided.
- Those for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.
- Those for orthodontic treatment over the Orthodontic Maximum.
- Those for general anesthesia and intravenous sedation; unless done in conjunction with all covered oral surgery procedures and select endodontic and periodontal surgeries.
- Those for treatment by other than a ***dentist***; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a ***dentist***.

- Those for a crown; cast; or processed restoration unless:
  - it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
  - the tooth is an abutment to a covered partial denture or fixed bridge.
- Those for pontics, crowns, cast or processed restorations made with high noble metals; except as specifically provided.
- Those for surgical removal of impacted wisdom teeth only for orthodontic reasons; except as specifically provided.
- Those for services needed solely in connection with non-covered services.
- Those for services done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
- Those for implants, implant abutments and related services (under the Basic Plan).
- Those for services and supplies not ***necessary***, as determined by Delta Dental, for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended or approved by the person's attending ***physician*** or ***dentist***.
- Those for care, treatment, services or supplies that are not prescribed, recommended or approved by the person's attending ***physician*** or ***dentist***.
- Those for or in connection with services or supplies that are, as determined by Delta Dental, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - if required by the FDA, approval has not been granted for marketing; or
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes.
- Those for services of a resident ***physician*** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies:
  - Furnished, paid for or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
  - Furnished, paid for or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In

addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for routine dental exams or other preventive services and supplies, except to the extent coverage for such exams, services or supplies is specifically provided in your Booklet.
- Those for acupuncture therapy.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to repair an injury. Surgery must be performed:
  - in the calendar year of the accident which causes the injury, Delta Dental approves any material for crowns, abutments, and pontics on posterior teeth. Delta Dental provides an alternate benefit for partial covering of a posterior tooth such as with a ¾ crown or onlay. In cases like this, the ¾ porcelain crown or onlay is given a ¾ metal crown or onlay as the alternate benefit. Those for a service or supply furnished by a Preferred Care Provider in excess of such provider's Negotiated Charge for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.
- Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
- Procedures to correct congenital or developmental malformations except for covered dependent children and newborn children eligible at birth.
- Plaque control programs, including oral hygiene and dietary instruction.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Applying for Benefits

How to File Claims

Claim forms are available from the Publicis Connections website, by accessing the Forms Library. Remember to take a form with you to your appointment.

Complete the employee portion of the claim form and make sure to sign it. Your ***dentist*** will complete the rest. You may use the same claim form whether or not your ***dentist*** is a participating ***dentist***.

Claim forms should be submitted to:

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Benefits for services provided by non-participating dentists will be paid to you, unless you assign payment to your non-participating ***dentist***. If you have a claim inquiry or a benefits-related question, contact Delta Dental's Customer Service Department toll-free at 1-800-932-0783**.**

Please make every reasonable effort to file claims as soon as possible after you incur the ***eligible expense***. Claims are not processed more than 12 months from the date of service. Your claim may be denied if you don't submit it in a timely manner.

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Delta Dental. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

Claims Review

See Appendix A (p. 45).

Internal Appeals Procedures

See Attachment One (p. 47).

Plan Administrative Committee Voluntary Appeal

If you are not satisfied with the appeal decision at the Claim Administrator (Delta Dental), you have the right to request an appeal from the Plan Administrative Committee within 60 days from receipt of the Delta Dental appeal determination. Upon receipt of a non–urgent pre–service or post–service appeal the Plan Administrative Committee shall render a determination of the appeal within 30 days after the appeal has been received.

Plan Administrative Committee appeals should be in writing and sent to:

Publicis Connections
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601

Please note plan participants may submit a written request to examine Claim and/or appeals documents free of charge. The Plan Administrative Committee will review all Claims in accordance with the rules established by the U.S. Department of Labor. Decisions on appeals by the Plan Administrative Committee will be final.

Limitation on Legal Action Against the Plan

You may not commence any legal action, including a court proceeding under Section 502(a) of ERISA, prior to the completion of all the administrative proceedings described in Attachment One. Also, even if there are other periods to commence an action prescribed by law or rule of a court or other forum, no action in any forum to enforce benefits or other rights under the Plan may be undertaken more than one year following the date you are notified of the final decision on appeal. If the claims administrator or plan administrator considers a claim, in whole or in part, after any period for action described above has elapsed, it is not waiving the Plan's rights to limit legal actions thereafter.

ERISA Rights

As a participant in the group benefit plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) that is 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 copies of the latest annual report (Form 5500 Series) and an 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.
- Receive a copy of the procedures used by the Plan for determining a qualified medical child support order.
- Continue health care coverage for yourself, your ***spouse***, or your 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 the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Please refer to the Administrative Information Summary Plan Description for specific ERISA information regarding your Benefit Plans.

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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and that of other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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. For instance, if you request materials 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 up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 status of a domestic relations order or a medical child support order, you may file suit in a 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 at:

Publicis Connections
Attn: Plan Administration Committee
35 West Wacker Drive
Chicago, IL 60601
1-800-933-3622

If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA, and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or
- the 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.

The Plan Administrator has delegated to the Claims Administrators the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, to make determinations (including factual determinations) as to the rights and benefits of employees and participants under the Plan, to make claims determinations under the Plan, and to decide the appeal of denied claims. Benefits will be paid under the Plan only if the Plan Administrator, or its delegate, determines that the claimant is entitled to them. The decision of the Plan Administrator or its delegate is final and binding.

Additional Information

Alternate Treatment Rule

If more than one service can be used to treat a covered person's dental condition, Delta Dental may decide to authorize coverage only for a less costly covered service provided that both of the following terms are met:

- the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- the service selected must meet broadly accepted national standards of dental practice.

Replacement Rule

The replacement of, addition to, or modification of:

- existing dentures;
- crowns;
- casts or processed restorations;
- removable bridges; or
- fixed bridgework

is covered only if one of the following terms is met:

- The existing denture, crown; cast, or processed restoration, removable bridge or bridgework cannot be made serviceable, and was installed at least five years before its replacement.
- Temporary upper and lower partial dentures are covered when there is an anterior extraction and healing is needed. Immediate dentures follow the same guidelines as standard dentures.

Benefits After Coverage Ends

This section applies to a person whose coverage ceases while not "totally disabled."

Dental services given after the covered person's coverage terminates are not covered. However, if the patient was a covered enrollee at the time treatment began, Delta Dental will pay for all work in progress, including teeth prepared for crowns, root canals in progress and the completion of a partial or full denture for which an impression has been taken, subject to applicable coinsurance, deductibles and maximums.

Delta Dental's obligation to pay toward orthodontic treatment terminates following the date the enrollee loses eligibility or upon termination of the client's contract.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Plan is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law. A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the plan's Notice of Privacy Practices, which is furnished to all Plan participants and can also be accessed on the Plan's internet site at www.PublicisConnections.com.

Glossary of Terms

Actively at Work

You are considered actively at work if you are:

- Working at the ***Company's*** usual place of business, or on an assignment for the purpose of furthering the ***Company's*** business;
- Performing the material and substantial duties of your regular occupation on a full-time basis; and
- Not receiving severance or salary continuation pay.

You're considered actively at work during a scheduled vacation or a holiday, during an approved leave under FMLA or on an approved personal leave of absence of less than 31 days.

Allowed Amount

The lesser of the applicable Delta Dental Maximum Plan Allowance or the dentist's actual fee, minus applicable coinsurance and deductibles ("Delta Dental Payment")**;** and when combined with your "Patient Payment" (applicable coinsurance & deductible charges, if any) this Allowed Amount **is accepted as payment in full for covered services provided by Delta Dental participating dentists.** *Note that the Delta Dental Payment will also take into consideration the annual dental benefit maximum.

Company

The term "Company" collectively refers to all subsidiaries of MMS USA Holdings, Inc. that have approved participation in the Publicis Connections Health and Group Benefit Programs.

Creditable Coverage

Coverage you have under any of the following:

- A group health plan;
- Health insurance coverage for medical care under any hospital or medical service policy or HMO contract offered by a health issuer;
- Medicare (Part A or B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act);
- CHAMPUS (Title 10 U.S.C. Chapter 55);
- The Indian Health Service or of a tribal organization;
- A state health benefits risk pool;
- The Federal Employees Health Benefits Program;
- A public health plan maintained by a state, county, or other political subdivision of a state;
- Section 5(e) of the Peace Corps Act; or
- Continued Coverage under COBRA.

Dentist

This means a legally qualified dentist. Also, a ***physician*** who is licensed to do the dental work he or she performs.

Domestic Partner

Your same or opposite sex domestic partner includes any individual that you have been residing with in the same residence for at least six months. You need to complete the Affidavit for Certification of Domestic Partnership (available in the Forms Library on the Publicis Connections website) before coverage begins.

You must meet all of the following to be eligible for coverage as a domestic partner:

- You have shared a monogamous, committed relationship with one another that has existed for at least six months and is expected to last indefinitely;
- You're jointly responsible for each other's welfare and financial obligations;
- You share your principal place of residence;
- You're both at least 18 years old and mentally competent to consent to the contract;
- Neither of you are married to anyone else; and
- You're not related to each other in a way that would prevent a marriage from being recognized under the laws of the state in which you live.

You also may be required to prove your interdependence (if requested). You can do so by providing two of the following documents:

- Common ownership of real property;
- Common ownership of a motor vehicle;
- Driver's license that lists a common address;
- Proof of joint bank accounts or credit accounts;
- Proof of designation as the primary beneficiary for life insurance or primary beneficiary designation under a partner's will;
- Assignment of a property power of attorney or health care power of attorney.

Eligible Expenses

All references to eligible expenses assume that charges are for covered services.

Jaw Joint Disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint; or
- A myofacial pain dysfunction (MPD); or
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Necessary

A service or supply furnished by a particular provider is "necessary" if Delta Dental determines that it is appropriate for the diagnosis, the care, or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply—both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply—both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

Occupational Injury or Disease

An occupational disease is an injury or disease that:

- Arises out of (or in the course of) any work for pay or profit; or
- Results in any way from an injury or disease that does.

Orthodontia Services

This is any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, the bite, or the jaws or jaw joint relationship—whether or not for the purpose of relieving pain.

Orthodontia services don't include the installation of a space maintainer or a surgical procedure to correct malocclusion.

Plan Administrator

The person or committee designated from time to time as the fiduciary responsible for overall administration of the Plan. Except as otherwise designated in the Administrative Information Summary Plan Description or by a notice from the ***Company***, the ***Plan Administrator*** may be contacted as follows:

Publicis Re:Sources USA
Publicis Benefits Department
Attn: Plan Administrative Committee
35 W. Wacker Dr., 12th Floor
Chicago, IL 60601
1-800-933-3622

Plan Year

The year starting January 1 and ending December 31.

PPO Provider

A general ***dentist*** or specialist who participates in Delta Dental's PPO network and who meets Delta Dental's credentialing standards and accepts ***Delta Dental's PPO Allowed Amount*** as payment-in-full for services rendered. PPO providers are listed in the provider directory.

Premier Provider

A general ***dentist*** or specialist who participates in Delta Dental's Premier network and who meets Delta Dental's credentialing standards and accepts ***Delta Dental's Premier Allowed Amount*** as payment-in-full for services rendered. Premier providers are listed in the provider directory.

Physician

A person who is legally licensed and qualified to practice medicine.

Spouse

Your spouse includes the individual to whom you are legally married under federal law. Note that under federal law a "common law spouse" will be recognized as a spouse only if relevant state law recognizes the person as a spouse despite the lack of a formal marriage.

Totally and Permanently Disabled.

The inability by reason of illness, injury, or physical condition to perform the material duties of any occupation for which you're qualified or you become qualified by reason of experience, education, or training. If you're a covered person other than an eligible individual, you're considered totally and permanently disability if you're unable by reason of illness, injury, or physical condition to engage in the normal activities of a person of the same age and sex who's in good health. In addition, you must have applied for and received a permanent disability status from the Social Security Administration.

Uniformed Services

Uniformed services include such military service as:

- Active duty;
- Active duty for training;
- Initial active duty for training;
- Inactive duty for training;
- Full-time National Guard duty; and
- Military fitness examinations.

APPENDIX A

(1) Denial of payment based upon lack of coverage of benefit under the Contract or Subscriber's eligibility status i.e., claim benefit determinations that are **not** considered Utilization Review under Article 49 of the New York Insurance Law.

If a post-service claim[1] is denied in whole or in part, Delta Dental shall notify the Subscriber and the attending dentist of the denial in writing within thirty (30) days after the claim is filed, unless special circumstances require an extension of time, not exceeding fifteen (15) days, for processing. If there is an extension, the Subscriber and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. If an extension is necessary because either the Subscriber or the attending dentist did not submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information. The Subscriber or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Subscriber's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

The notice of denial shall explain the specific reason or reasons why the claim was denied in whole or in part, including a specific reference to the pertinent Contract provisions on which the denial is based, a description of any additional material or information necessary for the Subscriber to perfect the claim and an explanation as to why such information is necessary. The notice of denial shall also contain an explanation of Delta Dental's claim review and appeal process and the time limits applicable to such process, including a statement of the Subscriber's right to bring a civil action under ERISA upon completion of Delta Dental's second level of review. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request).

If the Subscriber or the attending dentist wants the denial of benefits reviewed, the Subscriber or the attending dentist must write to Delta Dental within one hundred eighty (180) days of the date on the denial letter. In the letter, the Subscriber or attending dentist should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. The Subscriber or the attending dentist is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination.

[1] Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

The review shall be conducted on behalf of Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review is of a claim denial based in whole or in part on a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available to the Subscriber or the attending dentist upon request. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify the Subscriber and the attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send to the Subscriber or attending dentist a notice, which contains the specific reason or reasons for the adverse determination and reference to the specific Contract provisions on which the benefit determination is based. The notice shall state that the Subscriber is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the Subscriber's claim for benefits. The notice shall refer to any internal rule, guideline, and protocol that was relied upon (and that a copy will be provided free of charge upon request). The notice shall state that if the claim denial is based on lack of dental necessity, experimental treatment or a clinical judgment in applying the terms of the Contract, an explanation is available free of charge upon request by either the Subscriber or the attending dentist. The notice shall also state that the Subscriber has a right to bring an action under ERISA upon completion of Delta Dental's second level of review, and shall state: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If in the opinion of the Subscriber or attending dentist, the matter warrants further consideration, the Subscriber or the attending dentist should advise Delta Dental in writing as soon as possible. The matter shall then be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the Subscriber or the attending dentist. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board, or to the courts with an ERISA or other civil action.

(2) Denial of a covered benefit where the service is not dentally necessary, appropriate or efficient, i.e., claim benefit determinations that are considered Utilization Review under Article 49 of the New York Insurance Law.

ATTACHMENT ONE

DELTA DENTAL OF NEW YORK'S UTILIZATION REVIEW AND INTERNAL APPEALS PROCEDURES

I. Definitions

A. Adverse Determination shall mean a determination by a Utilization Review Agent that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary.

B. Appeal Determination shall mean a determination by Delta Dental of New York's Dental Affairs Committee that a health care service, upon review based on the information provided, is not medically necessary.

C. Clinical Peer Reviewer shall mean a physician who possesses a current and valid non-restricted license to practice medicine or a health care professional other than a licensed physician who: (1) where applicable, possesses a current and valid non-restricted license, certificate or registration or, where no provision for a license, certificate or registration exists, is credentialed by the national accrediting body appropriate to the profession, and (2) is in the same profession and same similar specialty as the Health Care Provider who typically manages the medical condition or disease or provides the Health Care Service or treatment under review.

D. Clinical Standards shall mean those guidelines and standards set forth in the Utilization Review Plan by the Utilization Review Agent whose Adverse Determination is under appeal.

E. External Appeal shall mean an appeal conducted by an External Appeal Agent pursuant to Section 4914 of the New York Insurance Law.

F. External Appeal Agent shall mean an entity certified by the superintendent pursuant to Section 4911 of the New York Insurance Law.

G. Final Adverse Determination shall mean an Adverse Determination which has been upheld by a Utilization Review Agent with respect to a proposed Health Care Service following a standard appeal, or an expedited appeal where applicable, pursuant to Section 4904 of the New York Insurance Law.

H. Health Care Provider shall mean a Health Care Service or a facility licensed pursuant to Article 28, 36, or 47 of the Public Health Law or a facility licensed pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law.

Terms in ***bold/italics*** are further defined in the Glossary.

I. Health Care Service shall mean: (1) for purposes of appeals requested pursuant to Paragraph two of Subsection b of Section 4910 of Title 2 the New York Insurance Law, Health Care Service shall mean experimental or investigational procedures, treatments or services, including services provided within a clinical trial, and the provision of a pharmaceutical product pursuant to prescription by the patient's attending physician for a use other than those uses for which such pharmaceutical product has been approved for marketing by the Federal Food and Drug Administration to the extent that coverage for such service is prohibited by law from being excluded under the plan, or (2) in all other cases, health care procedures, treatments or services provided by a facility licensed pursuant to Article 28, 36, 44, or 47 of the Public Health Law pursuant to Article 19, 23, 31, or 32 of the Mental Hygiene Law, or provided by a health care professional, and the provision of pharmaceutical products or services or durable medical equipment.

J. Subscriber shall mean a person subject to Utilization Review.

K. Utilization Review shall mean the review to determine whether a Health Care Service that has been provided is being provided or is proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such service, is medically necessary. None of the following shall be considered Utilization Review: (1) denials based on failure to obtain a Health Care Service from a designated or approved Health Care Provider as required under a contract, (2) where any determination is rendered pursuant to Subdivision 3(a) of Section 2807(c) of the Public Health Law, (3) the review of the appropriateness of the application of a particular coding to a patient, including the assignment of diagnosis and procedure, (4) any issues relating to the determination of the amount or extent of payment other than determinations to deny payment based on an Adverse Determination, and (5) any determination of any coverage issues other than whether a Health Care Service is or was medically necessary.

L. Utilization Review Agent shall mean any insurer subject to Article 32 or 43 of the New York Insurance Law performing Utilization Review and any independent Utilization Review Agent performing Utilization Review under contract with such insurer.

M. Utilization Review Plan shall mean: (1) a description of the process for developing the written clinical review criteria, (2) a description of the types of written clinical information which the plan might consider in its clinical review, including but not limited to a set of specific written clinical review criteria, (3) a description of practice guidelines and standards used by a Utilization Review Agent in carrying out a determination of medical necessity, (4) the procedures for scheduled review and evaluation of the written clinical review criteria, and (5) a description of the qualifications and experience of the health care professionals who developed the criteria, who

are responsible for periodic evaluation of the criteria and of the health care professionals or others who use the written clinical review criteria in the process of Utilization Review.

II. Standard Claims & Appeals Procedure

A. Claims for Benefits: In the case of a post-service claim[2] which has been denied on the basis that such service was not dentally necessary, Delta Dental shall notify the Subscriber and the attending dentist of its Adverse Determination in writing within a reasonable period of time, but not later than thirty (30) days after the claim is filed. However, this period may be extended one time by Delta Dental for up to fifteen (15) days, if necessary due to the failure of the Subscriber to submit the information necessary to decide the claim. If there is an extension, the Subscriber and the attending dentist shall be notified of the extension and the reason for the extension within the original thirty (30) day period. The notice of extension shall specifically describe the required information, and the Subscriber or the attending dentist shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specific information. The extension period (15 days) – within which a decision must be made by Delta Dental – will begin to run from the date on which the Subscriber's response is received by the plan (without regard to whether all of the requested information is provided) or, if earlier, the due date established by the plan for furnishing the requested information (at least 45 days).

B. Reconsideration of Adverse Determination: In the event the Utilization Review of a claim results in an Adverse Determination, and this determination was made *without attempting to discuss such matter with the attending dentist who specifically recommended the health care service, procedure or treatment*, the attending dentist shall have the opportunity to request a reconsideration of the Adverse Determination. Such reconsideration shall be conducted by the attending dentist and the Clinical Peer Reviewer making the initial determination or a designated Clinical Peer Reviewer if the original Clinical Peer Reviewer cannot be available. If the Adverse Determination is upheld after reconsideration, Delta Dental shall notify the Subscriber of the Adverse Determination as provided below in Section III (A).

C. Informal Inquiry Option: If a claim is denied in whole or in part, a Subscriber may make an informal inquiry regarding general program and eligibility questions by contacting Delta Dental via its toll-free number at 1-

[2] Delta Dental does not condition receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care. Additionally, Delta Dental does not conduct concurrent review relating to continued or extended health care services, or additional services for an insured undergoing a course of continued treatment.

800-932-0783. Every caller has access to a supervisor if dissatisfied with the response.

D. Non-emergency Appeals of Adverse Determination: In lieu of making an informal inquiry, a Subscriber or his or her attending dentist may choose to appeal the Adverse Determination. The Subscriber may do so within one hundred eighty (180) days, either by writing to Delta Dental or by calling Delta Dental at its toll-free number. Written acknowledgement of the filing of the appeal to the appealing party will be provided to the Subscriber and the attending dentist within fifteen (15) days of the filing of the appeal. The letter or oral request for appeal should state why the claim should not have been denied. Also any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. Both the Subscriber and the attending dentist are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the denied claim.

E. Notification of Information Necessary to Conduct the Appeal: If Delta Dental requires information necessary to conduct a standard internal appeal, Delta Dental shall notify the Subscriber and the attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information.

F. The Review: The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered in the initial benefit determination. If the review is of a claim denial based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such consultant. The identity of the Delta Dental dental consultant whose advice was obtained in connection with the denial of the claim whether or not the advice was relied upon in making the benefit determination is also available on request. In making the review, Delta Dental will not afford deference to the initial Adverse Determination. A clinical examination at Delta Dental's cost may be implemented, along with discussion among dentist consultants. At this point, the Subscriber may also request a hearing.

G. Final Adverse Determination: Delta Dental shall make a Final Adverse Determination within thirty (30) days of the date the request for appeal is received. Delta Dental shall advise the Subscriber and the attending dentist of the Appeal Determination within two (2) days of the rendering of such determination. Notification of the Final Adverse Determination will be provided in accordance with Section III (B) below.

H. Appeal to Delta Dental's Dental Affairs Committee: If in the opinion of the Subscriber or the attending dentist the matter warrants further consideration and the Subscriber chooses not to file an External Appeal pursuant to Section 4914 of the New York Insurance Article, the Subscriber or attending dentist should advise Delta Dental in writing as soon as possible. The matter shall be immediately referred to Delta Dental's Dental Affairs Committee. Delta Dental's Dental Affairs Committee, which contains at least one licensed dentist, will review the claim and either approve payment for the dental service or issue an Adverse Determination. If the Dental Affairs Committee requires information necessary to conduct the Internal Appeal, Delta Dental shall notify the Subscriber or attending dentist, in writing within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, Delta Dental shall request the missing information, in writing, within five (5) business days of receipt of the partial information. This stage can include a clinical examination, if not done previously, and a hearing before the Dental Affairs Committee if requested. The Dental Affairs Committee will render a decision within thirty (30) days of the request for further consideration. The decision of the Dental Affairs Committee shall be final insofar as Delta Dental is concerned. Recourse thereafter would be to the courts with an ERISA or other civil action or the filing of an External Appeal pursuant to Section 4914 of the New York Insurance Article, if the time period for doing so had not previously expired.

III. Distribution of Information to Subscribers/Attending Dentists Upon Entry of Adverse Determination

A. Content of Notification of Adverse Determination (See Exhibit A, attached hereto). A notice of an initial Adverse Determination will include:

1. The specific reason or reasons for the Adverse Determination including the clinical rationale, if any;

2. Reference to the specific plan provisions on which the Adverse Determination is based;

3. Instructions on how to initiate standard and expedited appeals including a description of the Delta Dental's review procedures and the time limits applicable to such procedures and a statement of the Subscriber's right to bring a civil action under Section 502(a) of ERISA upon completion of the second level of review of Delta Dental's Internal Appeals Procedure;

4. Instructions on how to initiate an External Appeal pursuant to Section 4914 of the New York Insurance Law;

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;

6. If the Adverse Determination is based on dental necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Subscriber's medical circumstances is available upon request;

7. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

B. Content of Notification of Adverse Determination on Review i.e., "Final Adverse Determination."(See Exhibit B, attached hereto). If after the claim is reviewed, Delta Dental continues to deny the claim, Delta Dental shall send the Subscriber/attending dentist a notice, which contains:

1. A clear statement describing the basis and clinical rationale for the denial as applicable to the insured including the specific reason or reasons for the determination, reference to the specific plan provisions upon which the Adverse Determination is based;

2. A clear statement that the notice constitutes the Final Adverse Determination;

3. The insured's coverage type;

4. The name and full address of Delta Dental's Utilization Review Agent;

5. Delta Dental's contact person and his or her telephone number;

6. A description of the health care service that was denied, including the dates of the service, the name of the facility and/or physician

proposed to provide the treatment and the developer/manufacturer of the health care service;

7. A statement that the Subscriber and the attending dentist may be eligible for an External Appeal and the time frames for requesting an appeal;

8. A clear statement written in bolded text that the forty-five (45) day time frame for requesting an External Appeal begins upon receipt of the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the Subscriber to request an External Appeal;

9. A copy of the standard description of the External Appeal process as developed jointly by the superintendent and commission, including a form and instructions for requesting an External Appeal;[3]

10. A statement that the Subscriber is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

11. A statement that when the Subscriber completes the second level of Delta Dental's Internal Appeals Procedure, the Subscriber will then have a right to bring an action under Section 502(a) of ERISA;

12. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, a statement that a copy of such will be provided free of charge upon request;

13. If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation applying the terms of the plan to the Subscriber's medical circumstances is available upon request;

14. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

[3] Such information will also be provided by Delta Dental within three business days of a request by a Subscriber or a Subscriber's designee.

IV. Cooperation with the External Appeal Agent

Delta Dental will facilitate the prompt completion of External Appeal requests by:

A. Transmitting the Subscriber's dental and treatment records pursuant to an appropriately completed release or release signed by the Subscriber or by a person authorized pursuant to law to consent to health care for the Subscriber and, in the case of dental necessity appeals, transmit the clinical standards used to determine medical necessity for the Health Care Service within three (3) business days of receiving notification regarding the identity and address of the certified External Appeal Agent to which the subject appeal is assigned.

B. Providing information requested by the assigned certified External Appeal Agent as soon as is reasonably possible, but in no event shall Delta Dental take longer than two (2) business days to provide the requested information.

C. Providing the form and instructions, developed jointly by the superintendent and commissioner, for the attending dentist to request an External Appeal in connection with a retrospective adverse utilization review determination under Section 4904 of the Insurance Law, within three (3) business days of an attending dentist's request for a copy of the form.

D. In the event that an Adverse Determination is overturned on External Appeal, or in the event that Delta Dental reverses a denial which is the subject of an External Appeal, Delta Dental shall make payment for the Health Care Service which is the basis of the External Appeal to the Subscriber.

E. No fee will be charged by Delta Dental to a Subscriber for an External Appeal.

NOTICE OF ADVERSE DETERMINATION

This notice, provided to you pursuant to the requirements of Article 49 of the New York Insurance Law and the United States Department of Labor Claims Procedure Regulations constitutes an Adverse Determination of your claim.

Reasons for the Determination

The NOTICE OF PAYMENT OR ACTION attached hereto outlines the specific reason(s) and the specific plan provision(s) on which the determination was based.

Availability of Clinical Review Criteria Relied Upon to Make this Determination

Upon request and free of charge, Delta Dental will provide to you a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

Instructions on How to Initiate a Standard Appeal

& How to Initiate an External Appeal

If you or your attending dentist want the denial of benefits reviewed, you or your attending dentist must contact Delta Dental, either in writing or by calling Delta Dental's toll-free number, 1-800-932-0783 ***within one hundred eighty (180) days of the date on this notice. Failure to comply with such requirements may lead to forfeiture of your right to challenge this denial, even when a request for clarification has been made.*** You should state why the claim should not have been denied. Also, any other documents, data, information or comments which are thought to have bearing on the claim including the denial notice, should accompany the request for review. You or your attending dentist are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether such information was submitted or considered initially.

The review shall be conducted for Delta Dental by a Clinical Peer Reviewer who is neither the Clinical Peer Reviewer who made the claim denial that is the subject of the review, nor the subordinate of such individual. If the review of a claim denial is based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of such dental consultant. The identity of such dental consultant is available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial Adverse Determination.

If after review, Delta Dental continues to deny the claim, Delta Dental shall notify you and your attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental shall send you and your attending dentist a notice, similar to this notice. If in the opinion of you or your attending dentist, the matter warrants *further* consideration, you have two choices: (1) you may continue to avail yourself of Delta Dental's Internal Appeals Procedure and eventually, upon completion of Delta Dental's second level of review, file an action in the courts pursuant to section 502(a) of ERISA; or (2) you may file an External Appeal with the New York Insurance Department. Attached hereto is "Standard Description and Instructions for Health Care Consumers to Request an External Appeal." More information on these two options will be provided to you after you complete the first level of review.

Additional Necessary information which Must be Provided in Order for Delta Dental to Render a Decision on your Appeal

If you should choose to avail yourself of Delta Dental's Internal Appeals Procedure, Delta Dental may require additional information in order to render a decision on your appeal. If this is the case, Delta Dental has attached to this notice a separate sheet containing of a list of such necessary information, which also explains why such material or information is necessary. Please submit such information to the address listed thereon. Please also include any other documents, data information or comments which you believe to have bearing on the claim including this denial notice.

NOTICE OF FINAL ADVERSE DETERMINATION

This Notice is to inform you that upon review of your request for appeal of the Adverse Determination of your claim for benefits, **Delta Dental continues to deny your claim**. Attached are copies of the following: (1) a copy of the standard description of and instructions for initiating New York's External Appeal process; and (2) an application form for requesting an External Appeal. Upon completion of the second level of Delta Dental's Internal Appeals Procedure, you will then have a right to bring an action under Section 502(a) of ERISA.

Please note that you or your attending dentist now have a right to file an External Appeal with the State of New York Insurance Department, but you must do so within forty-five (45) days from the date of your receipt of THIS NOTICE. Even though Delta Dental's plan provides for two levels of review, the forty-five (45) day time period for requesting an External Appeal begins upon receipt of THIS NOTICE, the Final Adverse Determination of the first level appeal, regardless of whether or not a second level appeal is requested. By choosing to request a second level internal appeal, the time may expire for you to request an External Appeal.

Additionally, you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Availability of Clinical Review Criteria Relied Upon to Make this Determination

Upon request and free of charge, Delta Dental will provide to you a copy of any documents, records or other information relevant to your claim for benefits, as well as any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying your claim.

1. Coverage Type:_____

2. Description of the Service for which payment was denied:

_____
_____
_____
_____

3. Basis and clinical rationale for the denial:

_____
_____
_____
_____

4. Specific criteria and standards, including interpretive guidelines on which the decision was based:

_____
_____
_____
_____

5. Plan provisions upon which the determination is based:

_____
_____
_____
_____

6. The following is the name, business address, and business telephone number of the Delta Dental representative who has responsibility for Delta Dental's Internal Appeals Procedure:

_____
_____
_____
_____

7. The following is the name, business address, and business telephone number of the Utilization Review Agent, if different from the answer provided in number 6, above:

_____
_____
_____
_____

By: _____
Title: _____
Date: _____