Maine Automobile Dealers Association Insurance Trust

GROUP DENTAL PLAN

(Revised January 1, 2010)

INTRODUCTION

The benefits and coverage described herein are provided through a trust fund established and funded by a group of employers.

This booklet describes the benefits available to you under the Maine Automobile Dealers Association Insurance Trust Group Dental Plan.

The benefits described in this booklet are those in effect as of January 1, 2010.

Every attempt has been made to be informative about benefits available under the Plan and those areas where a benefit may be lost or denied.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the employer, Plan Administrator, Contract Administrator, and such other individuals as may be party to or associated with the Plan shall be guided solely by this Summary Plan Description, which is also the Plan Document. It is the intention of the Employer that this document will comply with the pertinent provisions of the Employee Retirement Income Security Act of 1974, as amended.

The Plan Administrator shall have full discretionary authority to interpret this Plan, its provisions and regulations with regard to eligibility, coverage, benefit entitlement, benefit determination and general administrative matters. The Plan Administrator's decisions will be binding on all plan participants and conclusive on all questions of coverage under this Plan, subject to the plan participant's appeal rights described later in this plan document.

The Maine Automobile Dealers Association Insurance Trust hopes and expects to be able to continue the Plan indefinitely but reserves the right to make changes in the Plan or to discontinue the Plan at any time. Should the Plan be terminated, plan participants are notified at least ten (10) days in advance of the termination date. Any and all amendments to the Plan shall be in writing and shall be authorized by the signature of Thomas T. Brown Jr., as President of the Plan Administrator, the Maine Automobile Dealers Association, Inc.

TABLE OF CONTENTS

Plan Information

The Plan Name
The Maine Automobile Dealers Association Insurance Trust Group Dental Plan

The Plan Effective Date
January 1, 2010

Plan Identification (EIN) Number
01-0288347

Plan Number
The Group Benefits Plan Number for the Employer's IRS reporting is 10120.

Plan Year
The financial records the Plan are maintained on the basis of Plan Years commencing on June 1 and ending May 31.

The Sources of Contribution to the Plan
The Employer and Employees will contribute the total cost for the Plan.

Name of Plan Sponsor and Administrator
Trustees of the Maine Automobile Dealers Association Insurance Trust

Name, Address and Telephone Number of Plan Insurer
The Maine Automobile Dealers Association Insurance Trust
180 Civic Center Drive
P.O. Box 2667
Augusta, Maine 04338-2667
Telephone Number 207-623-3882

Contact Person: *Thomas T. Brown, Jr.*

Agent for Legal Service
The Agent for service of legal process is the Plan Administrator and service may be made at the above address. The eligibility requirements, termination provisions and a description of the circumstances resulting in disqualification, ineligibility or denial or loss of any benefits are described in this Plan Document.

Type of Coverage Provided Under The Plan
Group Dental Benefits

Type of Administration
Contract Administration By:
Anthem Dental
P.O. Box 659444
San Antonio, TX 78265
Toll-Free 1-877-205-7633

Plan Information

Eligible Classes of Employees
All regular, full-time employees of the Participating Trust Employer working at least 30 hours per week.

The Dental Plan does not base eligibility on any of the following health status-related factors: medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability.

The Waiting Period
For all new employees of the Participating Trust Employer employed after this Plan's effective date, the waiting period is the remaining portion of the calendar month in which they are hired and the entire following calendar month. (For example, an employee hired on Jan 14th waits the balance of January and all of February, coverage begins March 1st)

The Date Of Eligibility
For new employees and covered dependents, the date of eligibility occurs upon completion of the waiting period. For all other enrollees, the date of eligibility is the date the eligibility requirements have been satisfied, as defined herein.

The Effective Date of Coverage
Participation in the Plan is effective on the first of the month next following the date of eligibility.

Transfer provision
Covered employees who transfer from one participating dealership to another, and whose application is postmarked within 30 days of their termination date, shall not have a break in coverage.

Clerical Error
Any clerical error (by the employer, plan administrators or contract administrator) in keeping pertinent records or a delay in making an entry will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. An equitable adjustment will be made when the error or delay is discovered.

Misrepresentation
If you make any misrepresentation or use fraudulent means in applying for coverage or filing a claim for benefits, your coverage will terminate under this Plan.

Plan Re-Entry-
Any plan participant who was formerly covered under this Plan, either as an employee or as a dependent, and who again becomes covered hereunder, either as an employee or as a dependent, shall not have his full benefit maximum restored solely by reason of the fact that the individual has become covered for a second or subsequent time. The benefit maximum with respect to such individual, as defined herein, shall be reduced by any benefits previously paid under the provisions of this Plan.

Transfer of Coverage
This provision applies if this Plan replaces another group dental plan and only to those individuals covered by the other carrier on the day before this Plan went into effect. Credit will be given under this Plan for service requirements and deductibles met in part or in full under the provisions of the plan being replaced.

The following is an overview of this Plan's dental benefits. This summary explains how benefits will be paid. Covered services are subject to a calendar year deductible unless otherwise specified herein. A pre-treatment plan determination/review is recommended for treatment in cases involving costly or extensive treatment. The pre-treatment plan process is described herein.

Service	Calendar Year Deductible	The Plan pays	You pay[1]	Calendar Year Benefit Maximum
Preventive	No Deductible	100% R&C	0[1]	$1,250 per person
Basic	$50 per person	80% R&C	20% R&C[1]	
Major		50% R&C	50% R&C[1]	

[1]*The plan participant is responsible to pay any amount above the reasonable and customary allowance.*

HOW YOUR DENTAL PLAN WORKS

Deductible, Coinsurance and Benefit Maximum
Every calendar year each plan participant must satisfy a deductible, as defined above, before this Plan pays benefits. Once the deductible has been satisfied, benefits will be paid in accordance with the appropriate coinsurance allowance, as defined in "The Plan Pays/You Pay." Each calendar year, benefits will be paid to a benefit maximum, as defined herein.

Covered Dental Expenses
Covered dental expenses are the charges of a dentist or physician for the services and supplies required for dental care and treatment of any disease, defect or accidental injury, or for preventive dental care. Benefits are payable for covered dental expenses incurred not to exceed the reasonable and customary allowance as defined herein. Not included is any charge in excess of the charge customarily made:

1) For similar services and supplies by dentists or physicians in the locality concerned, or
2) Where alternate services or supplies are customarily available for such treatment, for the least expensive service or supply resulting in professionally adequate treatment.

Pre-Treatment Plan Review
When your dentist recommends extensive dental work be done, you can receive an estimate of benefit payment this Plan will pay by submitting a pre-treatment plan to the Contract Administrator. To submit a pre-treatment plan, have the dentist complete a claim form, indicating procedures to be performed and proposed fees. The Contract Administrator will review the claim form and issue an estimate of benefits to be paid.

The estimate of benefits does not, in itself, guarantee payment of benefits. It also does not determine dental necessity. It simply tells the benefits available under the Plan based on the information provided at the time the pre-treatment plan was reviewed. Actual benefit determination will be made once services are performed and a claim received. The decision for payment of benefits will be based on the provisions of this Plan and the plan participant's eligibility at the time the service is rendered.

EMPLOYEE AND DEPENDENT ENROLLMENT

An employee (and dependents) is considered properly enrolled only when a completed and signed Benefit Enrollment Form has been delivered to the participating employer.

Employee and Dependent Eligibility - Only employees who are defined as eligible on Page 2 of this Plan Document are covered. An employee will become eligible for dependent coverage on the later of the date of eligibility for employee coverage, or the date on which the employee acquires his first dependent.

If an employee and spouse are both eligible for employee coverage, only one will be eligible for coverage with respect to dependents. In addition, the spouse may be deemed to be a dependent and not an employee with respect to the parts of this Plan which provide both employee coverage and dependent coverage.

Effective Date For Employees and Dependents - If an employee enrolls for employee/dependent coverage on or before the date of eligibility, coverage shall become effective on the first of the month next following the date of eligibility, as defined herein. If an employee enrolls for employee/dependent coverage within 31 days after the date the employee becomes eligible for coverage, coverage shall be effective on the first of the month coinciding with or next following the date the enrollment form is signed.

Additional Dependents due to Marriage are eligible for coverage and will become effective the first of the month following receipt of the enrollment form provided the employee enrolls the dependent(s) and pays any required additional contributions within 31 days of the employee acquiring such dependent.

Adopted Children are eligible for coverage effective the date the employee assumes the legal obligation for total or partial support of the child in anticipation of adoption provided the employee enrolls the child for dependent coverage and pays any required contribution within 31 days following the date the employee assumes legal obligation in order for coverage to be effective on that date. ***Important Note: The eligible adopted child's claims will not be processed for payment until the child has been properly enrolled, as defined herein.***

Newborn Children are eligible for coverage effective from moment of birth provided the child is properly enrolled and any required contribution is paid within 31 days following the birth of the baby. ***Important Note: For the first 31 days from birth, the child need not be enrolled in order for claim benefits to be paid. However, for claims incurred after the first 31 days from birth, benefits will not be paid until the child has been properly enrolled, as defined herein.***

If an employee does not enroll for employee/dependent coverage within 31 days after his date of eligibility, he must wait for Open Enrollment, as defined herein. If an employee declines coverage and later wishes to enroll in the Plan, enrollment may only be made due to a Change in Family Status or Special Enrollment, as defined herein.

Open Enrollment - The Open Enrollment period is the period designated by the Plan during which the employee may elect coverage or modify his enrollment. Except for a change in family status, as outlined below, the Open Enrollment period is the only time the employee may change benefit options. The Open Enrollment period is the month of February. Coverage shall become effective on March 1st.

Special Enrollment - If the plan participant declines enrollment in the Plan because of coverage under other health insurance coverage, he may in the future be able to enroll in this Plan, provided that he meets one of the following of the applicable conditions outlined below, and the request for enrollment is made within 31 days after his other coverage ends. In addition, if the plan participant acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, he may enroll himself and his dependents, provided that he request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. Conditions required for enrollment:

1) The employee has declined enrollment in writing stating that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment;

2) When the employee declined enrollment in employee and/or dependent coverage, the employee and/or dependent had COBRA Continuation Coverage under another health plan, and COBRA Continuation Coverage under that other plan has since been exhausted; or
3) If the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA Continuation Coverage, either the other coverage has been terminated as a result of:
   a) Loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
   b) Employer contributions towards the other coverage have been terminated.

Status Change – With the exception of a Special Enrollment Period as described above, a benefit election can be changed during the year only if a plan participant experiences a status change as described below.

1) There is a change in the employee's legal marital status (as a result of marriage, death of a spouse, legal separation or annulment;
2) There is a change in the number of employee dependents (as a result of birth, adoption, placement for adoption, or death);
3) The employee, employee's spouse, or dependent terminates or commences employment;
4) There is a reduction or increase in the hours of employment by the employee, employee's spouse, or employee's dependent (as a result of a switch between part-time and full-time or commencement or return from an unpaid leave of absence);
5) There is an event causing an individual to satisfy or cease to satisfy the requirements for coverage as a dependent under the Plan (or one of the benefit options offered under the Plan); or
6) The employee's status changes in some other way that under federal law permits the employee to change benefit choices.

To enroll for coverage or to modify benefits, a benefit enrollment form must be completed and submitted to the Plan Administrator or Participating Employer within 31 days of the status change event. Coverage or modification of benefits will be effective on the first of the month next following the date of the status change event. (Exception: if enrollment is due to birth or adoption, the effective date is the date of the event, provided the participant has properly enrolled, as defined herein.)

Qualified Medical Child Support Order (QMCSO) - As required by the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), the Plan will recognize QMCSOs by providing benefits for Plan participant's children who are the subjects of such orders without regard to Plan limitations requiring that participants have custody of the children or that the children are designated as the participant's dependents for tax purposes. A QMCSO is a judgment, decree or order issued by a court, domestic relation's magistrate or administrator that provides for child support related to health benefits or enforces a state medical child support order under the Social Security Act (for Medicaid purposes). A medical child support order must have the following elements to be considered a QMCSO:

1) The name and last known mailing address of the Plan participant;
2) The name and address of each alternate recipient (the child);
3) A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined;
4) The period for which coverage must be provided; and
5) Each plan to which the order applies.

The Plan Administrator must receive the request for coverage within 31 days of the issuance of the court's order. The elements listed above will be used by the Plan Administrator to determine whether the order qualifies as a QMCSO. Plan participants will be notified of the Plan Administrator's decision within 31 days after submitting an order and will have 31 days from the date of notification to appeal.

Termination Date for Employees and Dependents - Employee coverage will terminate on the earliest to occur of the following dates:

1) The date on which the Plan is terminated;
2) The last day of the period for which contribution has been made, if the employee fails to make any contribution which may be required;

3) The last day of the calendar month in which the employee ceases to be included in a class of eligible employees;

4) The last day of the calendar month in which employment is terminated.

Coverage with respect to a dependent will terminate upon the earliest to occur of the following dates:
1) The date on which the employee's coverage terminates;
2) The last day of the calendar month in which the employee's dependent coverage under the Plan terminates;
3) The last day of the calendar month in which the employee ceases to be included in the classes of persons eligible for dependent coverage, including marriage;
4) The last day of the calendar month in which contribution has been made, if the employee fails to make any contribution which may be required;
5) The last day of the calendar month in which the covered dependent does not satisfy the eligibility requirements, as defined herein.

Leaves Of Absences and Return To Work Under Federal Family and Medical Leave Act - An employee who is granted a leave of absence under the Federal Family and Medical Leave Act is entitled to continue benefits under the Plan at the same level of contribution and under the same conditions as if the employee had continued employment up to a maximum period of up to 12 weeks in any 12 month period. However, the employer may recover from the employee the premiums paid for such benefits when the employee returns to work or before if so agreed. If the employee fails to return from leave for reasons other than the continuation or onset of a serious health condition, or other circumstances beyond the control of the employee, the employer may also recover premiums from the employee. The employer may require that an employee who is unable to return to work because of the continuation, recurrence, or onset of a serious health condition support his claim by certification from the health care provider. If an employee notifies the employer that he will not be returning to work, coverage will be terminated as of the date upon which the employee notifies the employer. The employee will be offered continuation of coverage through COBRA, as defined herein. If the employee does not return to work after twelve (12) weeks, eligibility in the Plan will be terminated and COBRA will be offered. An employee who returns to work following an approved leave of absence under the Federal Family and Medical Leave Act will not be subject to the Waiting Period for new employees, as defined herein.

Note: Employees must complete 12 months of service before being eligible for a leave of absence under the Federal Family and Medical Leave Act.

Absence From Work Due to an Approved Leave of Absence (other than under FMLA) - If an employee is granted a leave of absence (other than FMLA), participation in the Plan is continued, not to exceed 14 weeks and subject to payment of the necessary contributions. If the employee does not return to work before the end of the 14 weeks or does not continue the necessary contributions, eligibility in the Plan is terminated and COBRA is offered, as defined herein.

Leave provisions outline in Federal Family and Medical Leave Act or Approved Leaves of Absences (other than under FMLA) cannot be combined with one another.

Return To Work - An Employee who returns to active, full-time employment within 30 days following a leave of absence, temporary lay off or termination of employment shall not have a break in coverage. Employee's who return to active, full-time employment within 6 months (but not within 30 days as outlined above) shall not be subject to the waiting period applicable to new employees.

Return to Work Following Military Call Up to Active Duty - If an employee returns to active full-time employment following a military call up to active duty, the waiting period for new employees as defined herein will not apply. All benefits defined in this Plan Document will be restored to their status as of the employee's last day worked provided the employee applies for re-employment within 90 days of the date of discharge. Coverage under this Plan will be effective on the date the reservist returns to full-time active employment.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Federal law requires most employers sponsoring a group health plan to offer employees and their families the opportunity for a temporary extension of group health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This required notice provides a summary of a qualified beneficiary's rights and obligations under the continuation coverage provisions of the law. A "qualified beneficiary" is an employee, spouse of an employee, or dependent child of an employee who is covered under the health plan on the day before the qualifying event and will lose coverage as a result of the qualifying event. A qualified beneficiary also includes a child born to or adopted by a qualified beneficiary.

When Coverage May Be Continued - An employee, spouse, or dependent child covered by the employer's group health plan has the right to choose this continuation coverage if group health coverage is lost due to:

1) The death of a covered employee;
2) The voluntary or involuntary termination of the covered employee's employment (for reasons other than gross misconduct) or reduction of hours, of a covered employee's employment;
3) The divorce or legal separation of a covered employee from the employee's spouse;
4) The covered employee's becoming entitled to Medicare under Title XVIII of the Social Security Act;
5) A dependent child ceasing to be a "dependent child" of a covered employee as defined by the plan;
6) A proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

A qualified beneficiary does not have to show evidence of insurability to choose continuation coverage. The group health coverage he may continue is the plan he is enrolled in at the time he is entitled to elect continuation coverage.

Notification - Under the law the employee or a family member (a qualified beneficiary) has the responsibility to inform the employer within 60 days of a:

1) Divorce;
2) Legal separation;
3) Child losing dependent status under the group health plan.

When the employer is notified that one of the above three events has occurred, the employer will notify the qualified beneficiary that he can choose continuation coverage. The employer will also notify him that he can choose continuation coverage when any of the other events listed in this notice have occurred. In any case, he has 60 days from the date of the employer's notice to decide if he wants continuation coverage.

Cost - The qualified beneficiary pays the entire cost of continuation coverage. The cost of continuation coverage will not exceed 102% of the applicable premium for the 18-month period of continuation coverage. The cost of continuation coverage for an additional 11 months beyond the 18-month period, for totally disabled employees, will not exceed 150% of the cost of coverage under the group health plan. The first premium after electing continuation coverage is due within 45 days after the election. Subsequent premiums must be paid within a 31-day grace period following the due date. Failure to pay subsequent premiums within this time period will result in automatic termination of continuation coverage.

Termination of Coverage - The maximum period for which coverage may be continued is:

- *18 months* - if continuation is due to a voluntary or involuntary termination of employment (other than for gross misconduct) or a reduction in hours.
- *29 months* - if an individual or a qualified beneficiary is totally disabled (as determined under either Title II or Title XVI of the Social Security Act) at the time of termination or reduction in hours of employment and has given notice of the disability before the end of the 18 months, or becomes totally disabled within the first 60 days of COBRA coverage. In either case, the qualified beneficiary must provide notice of the disability within 60 days after the date of the disability determination.

- *36 months* - if continuation is due to any other reason as described previously in the *When Coverage May Be Continued* section, or if a second qualifying event occurs within the 18-month continuation period.

However, coverage also ends for any of the following reasons:

1) The premium for continuation coverage is not paid within 31 days of being due (grace period); a failure to timely pay premiums will result in a loss of coverage retroactive to the date through which premiums were last timely paid;
2) The qualified beneficiary first becomes covered under another group health insurance plan (after the date he elects COBRA Continuation Coverage), if that plan does not contain any exclusion or limitation with respect to any pre-existing conditions of such individual;
3) The qualified beneficiary becomes entitled to Medicare (actually covered by Medicare) after the election of COBRA;
4) The qualified beneficiary was divorced from a covered employee and later remarries and is covered under the new spouse's group health plan; and

5) The employer no longer provides group health coverage to any of its employees.

If an employee chooses continuation coverage after termination of employment or reduction in hours, any dependent who is a qualified beneficiary may extend this coverage for an additional time if another event occurs for which continuation is allowed. However, continuation coverage can never extend for more than 36 months from the date it originally began. If a qualified beneficiary does not choose continuation coverage, group health coverage will end the date he would otherwise become eligible for COBRA.

Coverage is not available through this Plan when the COBRA Continuance ends. Beneficiaries nearing the end of the COBRA Continuance should seek group or individual health coverage from another source. In order to give careful consideration to the possible factors (cost, evidence of insurability, pre-existing condition limitations, etc.) beneficiaries should begin the search for alternative coverage up to two months before the end of the COBRA Continuance.

COVERED EXPENSES

Preventive and Diagnostic Services

1) Routine oral exams--but not more than twice each calendar year;

2) Prophylaxis (scaling and cleaning of teeth) for adults (code D1110) and Children (code D1120), but not more than twice per member per calendar year. Periodontal cleaning/maintenance (code D4910), but not more than twice per member per calendar year;

3) Topical application of fluoride for children under the age of 18--but not more than once each calendar year;

4) Dental X-rays, including:
    a. Full mouth X-rays or series, including panoramic--but not more than once each three calendar years;
    b. Supplementary bitewing X-rays--but not more than twice each calendar year;

5) Tests and laboratory exams;

6) Sealants to caries-free and restoration-free occlusal, buccal, and/or lingual surfaces of permanent molars. Benefits are limited to a covered dependent under the age of 14, one sealant per tooth per lifetime.

Basic Services

1) Emergency oral exams and emergency palliative treatment;

2) Professional consulting fees if requested by an attending dentist;

3) Space maintainers, for members under age 18, including adjustments made to the original space maintainer when done more than six (6) months after it is installed. Benefits are limited to a maximum of two per lifetime. The replacement or repair of space maintainers is not covered;

4) X-rays needed to diagnose and treat a specific condition;

5) Oral surgery (includes extractions) including local anesthesia and routine post-operative care;

6) General anesthetics and intravenous sedation, when needed as part of oral or dental surgery;

7) Antibiotic and antimicrobial (code D4381) applications by the attending dentist;

8) Treatment of periodontal and other gum and mouth tissue diseases, including periodontal surgery;

9) Endodontic treatment, including root canal therapy, and a maximum of one retreat of a previous root canal per lifetime;

10) Restorations of diseased teeth with amalgam, silicate, acrylic, synthetic, porcelain, or composites. All restorations on one surface will be considered as a single restoration;

11) Repair or recementing of crowns, inlays, onlays, or bridgework (benefits for repair of bridgeworks is limited to once during a 12 month period);

12) Relining, rebasing, repair and adjustments of dentures (benefits for relining is limited to once in a 12 month period);

Dental Benefits

Major Services –
Benefits for major services are available immediately if the *Transfer of Coverage* provision applies, or after the member has been insured for 12 months.

1) Restorations of diseased teeth with inlays, onlays, gold fillings, crowns, or dental implants (including the surgical placement of an endosteal implant body and the healing cap.) --but only when these teeth cannot be restored with amalgam, silicate, acrylic, synthetic, porcelain, or composites;

2) First installation of removable dentures;

3) First installation of fixed bridgework, including inlays and crowns as supports;

4) Replacement of crowns, implants, inlays or onlays with new ones (when installation was at least 5 years prior);

5) Replacement of partial dentures, full removable dentures, or fixed bridgework with new ones, or teeth added to the existing dentures or bridgework (when installation was at least 5 years prior);

Normally, dentures will be replaced with dentures. But when only bridgework will produce a professionally adequate result, then bridgework will be the eligible expense.

GENERAL EXCLUSIONS

Benefits will not be provided for any service that is not necessary and appropriate, including the following services, regardless of whether they are provided, performed or prescribed by a dentist or physician. The list below is representative of the exclusions not covered. Any service not listed or specifically identified, as a covered service is presumed not covered. Dental services you receive are only covered when prescribed and/or ordered by a licensed dentist or physician. To be necessary and appropriate, a service must be consistent with accepted dental practice. This Plan's exclusions include:

1) Any expense for services not directly related to or necessary for the diagnosis or treatment of an illness or injury, except to the extent herein provided;

2) Any expense caused by war declared or undeclared or any act of war;

3) Any expense suffered while on full-time active duty in the armed forces of any country, combination of countries or international authority;

4) Any expense incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment (past or present), or which is compensable under a Workers' Compensation, Occupational Disease Act or Law;

5) Any expenses for military service related injuries or illness (past or present) furnished by a hospital or facility operated by any foreign government agency or the United States Government or any authorized agency of the United States Government or furnished at the expense of such government or agency;

6) Any expense resulting from any intentionally self-inflicted injury while sane or insane;

7) Any expense for illness or injury caused by or contributed to by engaging in an illegal occupation or by committing or attempting to commit a felony;

8) Any expense for services rendered by the plan participant or spouse, or by a parent, son, daughter, brother or sister of the plan participant or his spouse or by a member of the plan participant's household;

9) Any expense for which there is no legal obligation to pay, or for which no charges would be made if the individual had no coverage, except to the extent as provided herein;

10) Any expense which exceeds the reasonable and customary charges in the locality where it is rendered, as determined by industry standards;

11) Any expense relating to travel whether or not the travel was recommended by a physician;

12) Any expense for dental services or supplies:
    a) To the extent that they are in excess of the reasonable and customary charges;
    b) That are not necessary or customary according to the accepted dental standards; or
    c) That are not recommended or approved by the attending dentist;

13) Any dental expenses for cosmetic services. These services are always considered cosmetic:
    a) Veneers, facings or similar properties of crowns or pontics placed on or replacing;
    b) Teeth in back of the second bicuspid;
    c) Bleaching; and
    d) Personalization or characterization of dentures;

14) Any dental expense for congenital or developmental;

15) Any dental expense for any duplicate devices or appliances, including prosthetics;

16) Any dental expense for replacing lost, missing or stolen devices or appliances, including prosthetics;

17) Any dental expense for appliances, restorations or procedures for:
    a) Altering vertical dimension, except to the extent as defined herein;
    b) Restoring or maintaining occlusion;
    c) Splinting;
    d) Replacing tooth structures lost from abrasion or attrition; or
    e) Treating temporomandibular joint problems as defined herein;

18) Any dental expense for dental services not furnished by a dentist or denturist;

19) Any dental expense for oral hygiene, a plaque control program or dietary instruction;

20) Any dental expense for orthodontic services;

21) Any expense for taxes or shipping charges;

22) Any expense for services, supplies, or treatment not recognized by The American Dental Association as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or expenses for procedures, surgical or otherwise, which are specifically listed by The American Dental Association as having no dental value, unless specified as a covered expense elsewhere in the Plan;

23) Any expense for services *incurred* prior to the plan participant's effective date of this Plan or after the plan participant's termination date from this Plan, except to the extent as defined herein;

24) Any expense for any other service, supply or treatment not specifically provided for within this Plan Document.

25) Any expense for a replacement or modification of a partial or full removable denture, a removable bridge or fixed bridgework, or for adding teeth to any of these, or for a replacement or modification of a crown, gold restoration or implant unless that denture, bridge, bridgework, crown, gold restoration or implant was installed at least 5 years prior and the member has been covered for at least 12 months.

Dental Benefits

26) Any expense for any of the following services:
    a) An appliance or modification of one, if an impression for it was made before the person became a covered person.
    b) A crown, bridge or gold restoration, if a tooth was prepared for it before the person became a covered person.
    c) Root canal therapy, if the pulp chamber for it was opened before the person became a covered person.

Coordination of Benefits

For expenses covered under both this Plan's Medical and Dental Benefits, benefits are paid according to the following guidelines:

1) Eligible Expenses will be considered under the Medical Benefit Program first;
2) Eligible Expenses will then be considered under the Dental Benefit Program on a Coordination of Benefits basis;
3) All covered expenses are subject to the overall Plan maximum on the Medical and the Dental Benefit Program.

Right To Revision

If any of the benefits payable under The Plan are revised after the covered employee's effective date, benefits shall be payable for services incurred after the effective date of such revision based upon such revised benefit level, except that in each of the following three (3) specified circumstances benefits will continue to be payable at the benefit level in existence prior to the effective date of such revision.

1) In the case of appliances or modification of appliances, where the master impression was taken prior to the date of revision; or
2) In the case of a crown, bridge or inlay or onlay restoration, where preparation of the tooth or teeth had begun prior to the date of revision; or
3) In the case of root canal therapy, where the pulp chamber was opened prior to the date of revision.

The Plan applies only to dental services furnished to the plan participant while the Plan is in effect and after the effective date of the plan participant's coverage thereunder, except as defined herein.

This benefit plan contains a non-profit provision coordinating it with other benefit plans under which an individual is covered. The total of all benefits payable in any calendar year will not exceed 100% of the allowable expenses incurred during that calendar year. An "allowable expense" is any necessary, reasonable and customary expense covered by this Plan. "Plan" means these types of health benefits:

1) Any hospital or medical service plan for prepaid group coverage; and
2) Labor-management trusteed plans, union welfare plans, employer organization plans, employee organization plans, and professional association plans; and
3) Any other employee welfare benefit plan as described in the Employee Retirement Income Security Act of 1974, as amended from time to time; and
4) Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; included but not limited to personal injury insurance and medical benefits provision;
5) Group insurance or other coverage for a group of individuals including student coverage obtained through an educational institution.

"Plans" will not include benefits under any income replacement coverage.

When a claim is made the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits payable under all plans will not exceed 100% of the allowable expenses. No plan pays more than it would without the coordination provision.

Plans With a Coordination of Benefits Provision - For any plans that do have a coordination of benefits provision, this Plan determines the order of benefits using the first of the following rules which applies:

1) Non Dependent/Dependent - Any plan in which the plan participant is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan in which the plan participant is covered as a dependent of the employee will pay next.

2) Dependent Child/Parents Neither Separated Nor Divorced - For a dependent child who is covered under plans of both parents and the parents are not separated or divorced, any plan in which the child is covered as a dependent of the parent whose birth date occurs earlier in the calendar year will pay first. Any plan in which the child is covered as a dependent of the parent whose birth date occurs later in the calendar year will pay next. If the birth dates of the parents are the same, the plan, which has covered a parent for the longest time, will pay before the plan of the other parent.

3) Dependent Child/ Separated or Divorced Parents - For a dependent child who is covered under plans of both parents and the parents are separated or divorced, if there is not a court decree which fixes the responsibility for health care costs of the child, any plan in which the child is covered as a dependent of the parent who has custody will pay first. Any plan in which the child is covered as a dependent of the spouse, if any, of the parent who has custody of the child will pay next. Then, any plan in which the child is covered as a dependent of the parent who does not have custody will pay.

4) Active/Inactive Employee - The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5) Continuation Coverage - If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:
   a) First, the benefits of a plan covering the person as an employee (or as that employee's dependent);
   b) Second, the benefits of coverage purchased under the continuation plan.

In some cases, the order of payment may be unclear. When this happens, any plan, which covered the eligible person for the longest time, will pay first. Any plan which has covered the eligible person for the shortest time will pay last. Any person who claims benefits must give the Contract Administrator the information needed to coordinate benefit payments.

Assignment of Benefits

The plan participant may authorize the Plan Administrator to pay benefits directly to the hospital, physician or other party providing medical treatment. The employee remains obligated by the terms of the Plan to pay the deductible, coinsurance and copayment specified by the Plan as a condition for the payment of benefits. Any such payment will discharge the Plan Administrator to the extent of payment made.

No payments are due from plans if participants or beneficiaries are not legally responsible for expenses incurred (other than advance payments made in contemplation of subrogation, in the case of an injury caused by a third party).

HOW TO SUBMIT A CLAIM FOR BENEFITS

The administration of the Plan and interpretation of all Plan provisions is the responsibility of the Plan Administrator. The Plan Administrator has contracted with the Contract Administrator (Anthem Dental) to perform many of the administrative duties connected with the Plan.

Claims should be submitted to the Contract Administrator promptly on the appropriate claim form, which can be obtained from the employer, if needed.

The address to file a claim directly to the Contract Administrator is:

Anthem Dental Claims
P.O. Box 659444 San Antonio, TX 78265
Toll-Free: 1- 877-205-7633

PROOF OF LOSS

"Proof of Loss" means a claim for payment along with enough information for the Contract Administrator to accept or reject the claim and to determine the benefits payable under the Plan. If this determination requires discretionary interpretation of Plan provisions, the matter will be referred to the Plan Administrator. The plan participant is encouraged to submit claims within 90 days after the date of service(s) and in no case later than one year after the date of service. Failure to submit claim(s) within the time required, except in the absence of your legal capacity, will invalidate the claim.

At least once a year, each plan participant should complete a claim form, as it contains information, which needs to be updated from time to time.

When the plan participant files his own claim, the following information should be included:
1) Patient's name;
2) Date the service was rendered;
3) Charge for the service rendered;
4) Diagnosis;
5) Description of the service rendered; and
6) Provider's name.

Claims For Dependent Children Enrolled in College - When a claim is submitted for a dependent child enrolled in an accredited college or university, proof of enrollment in the form of a paid tuition receipt or letter from the registrar must be submitted. Proof of enrollment must be submitted every six (6) months.

HOW BENEFIT DETERMINATIONS ARE MADE

Once a claim is filed, it is reviewed and processed. A benefit determination is then issued to the plan participant or his authorized representative. Determinations are made within a reasonable period of time appropriate to the claim's circumstances. A period of time begins at the time the claim is filed. There are different types of claims and each one has a specific timetable for either approval, payment, request for further information or denial of the claim.

For the purposes of this Plan, "days" mean calendar days. Below are other definitions, which are important in understanding how benefit determinations are made.

Adverse benefit determination means a denial, reduction or termination of benefits, or a failure to provide or pay for benefits.

Post-service claim means any claim that is submitted for benefit determination after services have been provided to a plan participant. It does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

Authorized Representative means the ordering provider, facility, or attending physician/dentist. The Contract Administrator works directly with the requesting provider for the review. Written communication of the need for additional information and the final determination will be sent to the plan participant or his authorized representative, the dentist, or other provider.

To designate someone other than the requesting provider as an authorized representative for purposes of claim review, the plan participant can submit a written statement to the Contract Administrator. The designated representative must be 18 years or older.

Determination Making Time Frames

Post –Service Claim Review

For review of services that have already been rendered and a claim is submitted, a determination will be made within thirty (30) calendar days from the time the claim is received by the Contract Administrator.

If additional information is needed to certify a post-claim review, the Contract Administrator will notify the plan participant or his authorized representative and the provider submitting the claim in writing of the specific information necessary to complete the review within thirty (30) calendar days after receipt of the request.

The plan participant or his authorized representative and the requesting provider have a reasonable amount of time, taking into account the circumstances, but not less than forty-five (45) calendar days from the date of the Contract Administrator's request, to provide the information.

Written notice of determinations concerning reviews of a post-service claim will be provided to the plan participant or his authorized representative and the provider(s) within 30 calendar days of the date the claim was received by the Contract Administrator but not later than 15 calendar days after expiration of the period to submit the requested information. The Contract Administrator is permitted to provide the plan participant with written notice for a 15-day review extension when additional review time is needed due to circumstances beyond the control of the Plan or the Contract Administrator.

Denial Letters

Denial letters will include the following, as appropriate:

1) A statement of the specific medical/dental and scientific reasons for the adverse determination;
2) A statement that upon request and free of charge, the specific criteria relied upon in making the non-certification determination shall be provided;
3) A reference to the specific Plan provision upon which the determination is based, if applicable;
4) A statement of the right to reconsideration;
5) A statement that the plan participant has the right to bring a civil action under Section 502(a) of ERISA if the plan participant is covered by an employer-sponsored health benefit plan subject to ERISA;
6) A description of appeal rights and the time limits applicable to initiating such rights; and
7) A description of the expedited review process for urgent care requests.

Access to Documentation

Upon request, the plan participant will be provided reasonable access to and copies of documents, records, and other information relevant to the request. This will be provided free of charge.

Right to Receive and Release Information- For the purposes of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or plan participant for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any plan participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Right To Make Payments - The Contract Administrator has the right to pay any other organization as needed to properly carry out this provision. These payments are made in good faith and are considered benefits paid under this Plan. Also, they discharge the Contract Administrator from further liability, to the extent that payments are made.

Right to Request Examination

The Plan Administrator at its own expense shall have the right and opportunity to request examination by an appropriate medical professional of the person of any individual whose injury or illness is the basis of a claim under the Plan and to have an

appropriate medical professional conduct an autopsy in case of death, where it is not forbidden by law. No action at law or in equity shall be brought to recover from the Plan prior to the expiration of 60 days after written claim has been submitted

in accordance with the requirements of the Plan. No such action shall be brought, after the expiration of the shortest period of time permitted by the laws of the state in which the Plan is issued, after the time written claim is required to be submitted.

Right To Recovery – If on behalf of the Plan the Contract Administrator paid more than it should have, the Contract Administrator has the right to recover the excess amount. This recovery can be from the person for whom the payments were made. It can also be from any other insurance company or organization.

APPEALS PROCEDURE

If the plan participant wishes to appeal a claim denial or reduction of benefits, a written request must be presented to the Contract Administrator within 180 days from the date appearing on the notice of denial or reduction in benefits. The plan participant may submit written comments, documents, records and other information relating to the claim.

The plan participant has the right to review the facts relating to the original determination and any additional information provided. The plan participant may also review this information with the Plan Administrator. If the plan participant so requests, he will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A document, record or other information shall be considered relevant to a claim if it:

1) Was relied upon in making the benefit determination;
2) Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination; or
3) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the plan. This timing is without regard to whether all the necessary information accompanies the filing. The Contract Administrator will present the plan participant with the final written determination within 60 days after receiving the appeal for a post-service claim.

In special cases, the Contract Administrator can extend the period for up to an additional 60 days. The plan participant will be notified in writing when an extension is required.

The review shall take into account all comments, documents, records and other information submitted by the plan participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The written determination will include specific reasons for the determination and cite the specific Plan provisions on which the determination is based. If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the plan participant is not satisfied with the appeal determination, he is entitled to pursue legal remedies under ERISA section 502(a) or other applicable law.

Legal Action Against The Plan

No legal action may be brought against The Plan until the plan participant or the plan participant's authorized representative has exhausted the appeals process outlined above. Any action must be initiated within three (3) years from the date of issuance of the underlying adverse Appeal decision.

ERISA RIGHTS

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

Examine, without charge, at the Plan Administrator's office and at other specified locations all Plan Documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Plan 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 (when such report is required).

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 the interest of you and other plan participants and beneficiaries.

No one, including your employer 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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

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 case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. 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 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 the court finds that your claim is frivolous.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

For Plan participants who reside in New England and upstate New York, the nearest Employee Benefits Security Administration office is:

Boston Regional Office
JFK Federal Building, Room 575
Boston, MA 02203
(617) 565-9600

Definitions

The following words and phrases are not intended to imply that coverage for them is provided under the Plan.

Accident - An unforeseen or unexplained sudden injury occurring by chance, without intent or volition.

Benefit Maximum - The maximum calendar year benefit amount shown in "Summary of Dental Benefits" section for which benefit are payable.

Calendar Year - Commencing on January 1 and ending on December 31.

Contract Administrator – Anthem Dental

Contributory Coverage - Group plan benefits for which an employee enrolls and agrees to make any required contributions toward the cost of coverage.

Copayment/Coinsurance Amount - The dollar amount or percentage amount shared by the Plan and the plan participant as defined herein.

Deductible - The sum of eligible expenses that a plan participant must pay out of his own pocket each calendar year before the Plan pays him a benefit.

Dental Services - Procedures involving the teeth, gum or supporting structures.

Dependent –

1. The eligible employee's legal spouse, as recognized under the Internal Revenue Code, provided such spouse is not legally separated from the employee;
2. The eligible employee's /spouse's unmarried children under age 19 as of the close of the calendar year, including:

a. Newborn children;

b. Biological children, adopted children or children placed for adoption, stepchildren or legally placed foster children who live with the employee;

3. The eligible employee's /spouse's unmarried children if they are dependent on their parents for their support, and are:

   a. Under age 25, not married and enrolled full time as a student at any time during the calendar year. (Note: Coverage may continue for an unmarried dependent child while he or she is unable to remain enrolled in school on a full-time basis due to a mental or physical illness or accidental injury until the dependent child reaches the age of 25.) Additionally, college students meeting all other eligibility criteria are permitted to take one semester off from college, for any reason, during their college career without losing eligibility. College students are considered eligible for coverage until the last day of the third month following their month of graduation. Proof of ongoing eligibility must be submitted annually. Every year, two months before the child's birthday, the Contract Administrator will send you a form that requires certification of ongoing student status and eligibility under the Plan; or,

   b. Mentally or physically disabled and incapable of earning a living. The disability must have begun before the child's 25th birthday, and the child must have been covered by the Plan on and continuously since his or her 19th birthday. The employee must submit proof of the child's disability.

4. The eligible employee's adopted grandchild under age 25, living with the employee in a parent-child relationship and primarily supported by the employee. The employee may not enroll a child and grandchild at the same time under the same identification/policy number. The eligible child or grandchild may be covered under a separate identification/policy number.

If an employee and spouse are both eligible for employee coverage, only one will be eligible for coverage with respect to dependents. In addition, the spouse may be deemed to be a dependent and not an employee with respect to the parts of this Plan which provide both employee and dependent coverage.

If a child is eligible for employee coverage under this Plan or another group medical benefit plan, that child is not eligible for dependent coverage.

Definitions

When a covered child reaches age 19, the Contract Administrator will send you an application. You must file this application with the Participating Trust Employer if you want the child's coverage to continue. The Contract Administrator will periodically require proof of ongoing eligibility, as previously described.

The Plan Administrator will determine the effective date of coverage for the employee and other eligible family members. If your coverage has changed or you are unsure of your effective date, please call the Plan Administrator.

The Plan Administrator and Contract Administrators reserve the right to verify continued eligibility for all Plan Participants.

Employee - Any employee of the participating employer who qualifies as outlined on Page 1 of this Plan Document.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period.

ERISA - The Employee Retirement Income Security Act of 1974, as amended from time to time.

Expense - A charge a person is legally obligated to pay. Unless otherwise defined herein, expenses are deemed incurred on the date the service or supply is furnished.

Full-Time - The term used herein will mean individuals regularly employed by the participating employer in the usual course of business and working at least the number of hours per week established by the employer as the normal work week, but in no event less than the number of hours shown on Page 1 of this document.

Incurred – Expenses are deemed incurred on the date the service or supply is furnished, except:

a. For an appliance, or a modification of one, on the date the impression is made;
b. For a crown, bridge or gold restoration, on the date the tooth/teeth is/are initially prepared;
c. For root canal therapy, on the date the pulp chamber is opened;
d. For any other expense, on the date the service is rendered or supply is furnished.

Expenses are applied in the order incurred.

Injury - Bodily harm which results from an accident and which results in loss covered by the Plan.

Participating Employer - An employer participating in and making the required periodic monetary contributions toward the cost of The Maine Automobile Dealers Association Insurance Trust.

Plan Participant - A covered employee or a covered dependent.

Pronouns - *Masculine* pronouns used herein shall apply to both sexes.

Reasonable and Customary (R&C) Charge - Any charge which does not exceed the usual fee for comparable services charged by licensed dentists, physicians and technicians in the area with training, experience and professional standing comparable to those who render the service in that geographical area, as determined by industry standards.

The Plan - The Group Dental Benefits as described in the Plan Document.