Northern Minnesota Dental, Inc.

..... Program of Dental Benefits .....

City of Hibbing

Dental Plan

Employer Dental Plan:

This Dental Plan is issued by the City of Hibbing for the benefit of its employees, their spouses, and dependent children. The City of Hibbing hereby agrees to provide the dental services described in this Dental Plan subject to exclusions, limitations, and conditions set forth herein.

The City of Hibbing has entered into an agreement with Northern Minnesota Dental, Inc. ("NMD") to arrange for the provision of the dental services described in this Dental Plan. NMD has entered into agreements with Member Dentists to provide the dental services covered by this Dental Plan.

This Dental Plan shall be effective January 1, 2026.

Schedule of Dental Plan Benefits

.....Employees are free to go to the dentist of their choice. .....

Plan Year ..... *January 1st through December 31st*

Basic Dental Plan (*Non-Member Dentist*):

- The Dental Plan provides for indicated percentage of the usual and customary fees up to a maximum per year.
- **You can be billed for fees in excess of what is determined usual and customary.**

• **Coverage A**	*Diagnostic and Preventative Services:*	**100%**
• **Coverage B**	*Basic and Special Restorative Services:*	**80%**
• **Coverage B1**	*Special Restorative Services:*	**80%**
• **Coverage C**	*Prosthetics:*	**80%**
• **Coverage D**	*Orthodontics:*	**50%**
• **Coverage E**	*TMJ (Temporomandibular Joint Dysfunction):*	**0%**

Maximum Benefits		
• Coverage A • Coverage B • Coverage B1 • Coverage C	$1,000.00	Per person per year
• Coverage D	$1,000.00	Per person per lifetime (*eight (8) to nineteen (19) years of age*)
• Coverage E	No Coverage	
• Deductible	$0.00	

Enhanced Dental Plan (*Member Dentist*):

- The Dental Plan provides for indicated percentage of the usual and customary fees up to a maximum per year.
- **You cannot be billed for fees in excess of what is determined usual and customary.**

• **Coverage A**	*Diagnostic and Preventative Services:*	**100%**
• **Coverage B**	*Basic and Special Restorative Services:*	**80%**
• **Coverage B1**	*Special Restorative Services:*	**80%**
• **Coverage C**	*Prosthetics:*	**80%**
• **Coverage D**	*Orthodontics:*	**50%**
• **Coverage E**	*TMJ (Temporomandibular Joint Dysfunction):*	**0%**

Maximum Benefits		
• Coverage A • Coverage B • Coverage B1 • Coverage C	$1,000.00	Per person per year
• Coverage D	$1,000.00	Per person per lifetime (*eight (8) to nineteen (19) years of age*)
• Coverage E	No Coverage	
• Deductible	$0.00	

Prior Authorization:

A prior authorization of costs with the appropriate p.a. x-rays and narrative must be submitted to NMD for any dental treatment involving major restorative, periodontic, prosthetic, or orthodontic care. This is to verify that the proposed treatment is covered by NMD, benefits, and estimate the amount of payment.

Failure to submit a prior authorization of costs before treatment is performed will result in the patient being responsible for payment of any dental treatment not approved by NMD.

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Section I: *Dental Plan Definitions*

For purposes of this Dental Plan:

1. **"Co-payment"** means the charge the covered person is required to pay for certain dental services. The covered person is required to pay any co-payment directly to the dentist at the time the service is rendered.

2. **"Covered Person"** means an employee or former employee of an employer who is eligible for dental benefits pursuant to the rules of the employer.

3. **"Congenital Anomaly"** means a defective oral development or formation that is determined by a dentist to have been present since birth.

4. **"Dependent Children"** means the employee's own or legally adopted unmarried children under the age of twenty-five (25), who are primarily dependent on the employee for support and maintenance. A dependent child also includes a child for whom the employee or the employee's spouse has been appointed legal guardian. A dependent child twenty-five (25) years of age or older shall not be eligible for coverage under this Dental Plan unless such child is disabled.

   A child is disabled if he or she is incapable of self-sustaining employment by reason of a mental or physical handicap and is primarily dependent on the employee for support and maintenance. The employee shall furnish the employer and / or NMD with proof of disability upon request by the employer and / or NMD. A disabled child shall be eligible for coverage regardless of age.

   A dependent child shall continue to be eligible for coverage until the age of twenty-five (25) if the child is unmarried and not regularly employed on a full-time basis.

5. **"Deductible"** means the annual amount of charges for dental services that a covered person is required to pay in advance of any coverage of dental services provided by a Member and / or Non-Member Dentist as specified on the Schedule of Dental Plan Benefits.

6. **"Dental Services"** means the dental care services and supplies eligible for coverage under this Dental Plan.

7. **"Emergency"** means a serious dental condition resulting from the sudden onset of physical illness or accidental injury to teeth and gums, which requires immediate care and treatment to avoid permanent harm to the covered person.

8. **"Dentally Necessary"** means a dental service which is required for the treatment of a dental condition that is consistent with accepted dental practice in the State of Minnesota and that could not be omitted without adversely affecting the patient's condition.

9. **"Member Dentist"** means a doctor of dental surgery "*DDS*" who is duly licensed to practice dentistry in the State of Minnesota and who has entered into a Participation Agreement with NMD to provide dental services to covered persons.

10. **"Non-Member Dentist"** means a doctor of dental surgery "*DDS*" who is duly licensed to practice dentistry in the State of Minnesota or any other state who has not entered into a Participation Agreement with NMD to provide dental services to covered persons.

11. **"Treatment Plan"** means a program of dental care services performed or to be performed by a Member or Non-Member Dentist.

12. **"Participation Agreement"** means the contract between a Member Dentist and NMD whereby the Member Dentist agrees to provide dental services to covered persons.

13. **"Prior Authorization"** means a requirement that NMD approve a treatment plan or dental service prior to providing dental services to a covered person.

14. **"Usual and Customary Fees"** means fees for dental services that do not exceed the usual fees charged by dentists of similar training and experience for the same services within the same geographic area as determined by NMD.

15. **"Coverage Year"** means a twelve (12) month period of time over which the deductible (*if any*) and maximums apply and is measured from the date this Dental Plan initially became effective.

16. **"Termination Date"** means the date of coverage for dental services shall cease pursuant to Section II of this Dental Plan.

Section II: *Termination of Coverage*

Coverage for dental services of any covered person shall terminate on the earliest of the following termination dates:

1. The date the contract between NMD and the employer is terminated.

2. The date the employer and / or NMD receives written notice from the covered person requesting termination of coverage, or the date requested in such notice, if later.

3. The last day of the month in which the employee retires, is terminated from employment, or suffers a reduction in hours resulting in loss of dental coverage, except where the employee, spouse, or dependent children elect continuation of dental care coverage pursuant to Section III of this Dental Plan.

4. *For an employee's spouse and dependent children:* The last day of the month in which an employee dies or becomes entitled to Medicare benefits or the employee's spouse becomes legally separated from the employee, or dependent children elect continuation of dental care coverage pursuant to Section III of this Dental Plan.

5. *For any dependent children:* The last day of the month in which a dependent child is eligible for coverage under this Dental Plan, except where the dependent child elects continuation of dental care coverage pursuant to Section III of this Dental Plan.

Section III: *Continuation of Coverage (COBRA)*

Coverage under this Dental Plan may continue subsequent to certain termination dates, if the employer provides extension of non-core benefits, and if the covered person elects in writing to continue coverage and assumes responsibility for the payment of any applicable premium as set forth in this Section.

Should the employer terminate coverage with NMD, the employees' coverage with NMD will terminate, and the employee's previous employer will be notified of the number of months of continuation coverage the employee has remaining.

1. *Qualifying Events:* Coverage under this Dental Plan may be continued by the employee for the employee and their covered dependents if coverage terminated due to any of the following qualifying events:

   (a) Employment terminates for any reason except gross misconduct.

   (b) The employee is laid off from their employment.

   (c) The employee has a reduction in work hours.

   (d) Coverage as a retiree is substantially reduced or eliminated with one (1) year before or after the employer files bankruptcy under Chapter 11, United States Code.

   (e) The employee becomes divorced.

   (f) The employee's death.

   (g) Coverage for covered dependents terminates due to the employee's enrollment in Medicare.

   (h) Covered dependent children become ineligible for coverage under this Dental Plan.

2. *Continuation Period:*

   (a) If an employee is terminated, laid off, has a reduction in work hours, or is an early retiree from their employment, the employee and their covered dependents may continue coverage until the earlier of:

      1) Eighteen (18) months after coverage terminates.

      2) The date coverage would otherwise have terminated under Section 4.(a) below.

   (b) Covered dependents may continue coverage after the divorce or death of the employee, until coverage would otherwise have terminated under 4.(a) below.

   (c) Covered dependent children who lose coverage due to becoming ineligible may continue until the earlier of:

      1) Thirty-six (36) months after coverage terminates.

      2) The date coverage would otherwise have terminated under Section 4.(a) below.

   (d) Covered dependent children may continue coverage after the employee's enrollment in Medicare until the earlier of:

      1) Thirty-six (36) months after coverage terminates.

      2) The date coverage would otherwise have terminated under Section 4.(a) below.

   (e) Retirees whose coverage is substantially reduced or eliminated within one (1) year before or after the employer files bankruptcy may continue coverage until the earlier of:

1) The employee's death.

2) The date coverage would otherwise have terminated under Section 4.(a) below.

(f) Covered dependents of retirees whose coverage is substantially reduced within one (1) year before or after the employer files bankruptcy may continue coverage after the retiree's death until the earlier of:

1) Thirty-six (36) months after coverage terminates.

2) The date coverage would otherwise have terminated under Section 4.(a) below.

(g) If the employee is disabled and is no longer able to work, the employee and their covered dependents may continue coverage until the earlier of:

1) Twenty-nine (29) months after coverage terminates.

2) The date total disability ends.

3) The date the employee becomes eligible for Medicare.

4) The date coverage would otherwise end under Section 4.(a) below.

3. *Second Qualifying Events:* A covered dependent who is being covered under continuation coverage due to a qualifying event will be entitled to elect a second period of continuation if one of the following qualifying events occurs:

(a) The divorce of the employee and spouse.

(b) The employee's death.

(c) The employee's enrollment in Medicare.

(d) The loss of eligibility as a covered dependent child.

The covered dependent must notify the NMD office of the second qualifying event within thirty (30) days after it occurs. The covered dependent may elect a second period of continuation, and the maximum period of time for the second period of continuation will be as described for that qualifying event under Section 2: "*Continuation Period*". In no event will the second period of continuation extend beyond the date coverage would otherwise terminate under Section 4, or for a dependent child, thirty-six (36) months after becoming ineligible for coverage.

4. *Termination of Continuation*

(a) Continuation will not be available or will terminate prior to expiration of the above stated period for all "*Qualifying Events*" except as specified in Section 1.(d) if any of the following occur:

1) The employer ceases to provide dental coverage to any employee.

2) The employee or covered dependent fails to pay the required contribution.

3) The employee or covered dependent becomes enrolled in Medicare.

4) The employee or covered dependent obtains coverage under another group dental plan.

5) The employer ceases to provide coverage to the classification of employees to which the employee or covered dependent belongs.

6) The Dental Plan terminates.

(b) Continuation for Section 1.(d) will not be available or will terminate prior to expiration of the above stated period if any of the following occur:

1) The employee or covered dependent obtains other group dental coverage.

2) The employer ceases to provide coverage to any employees or retirees.

3) The Dental Plan terminates.

4) The employee or covered dependent fails to pay the required contribution.

5. *Notice of Continuation Rights:* The employee, spouse, or covered dependents eligible for continuation coverage must make written application to NMD. NMD must receive notification within thirty (30) days of any continuation rights available after the employee's death, termination, reduction in work hours, or enrollment in Medicare. In the event of a divorce, or any changes in dependent status, NMD must be notified within sixty (60) days of the qualifying event. Failure to notify NMD in a timely manner will abrogate the rights of continuation.

   NMD or the employer must notify by mail, to their last known address, all eligible individuals of their continuation rights under this provision within fourteen (14) days after receiving notice of a qualifying event.

   The employee or covered dependents must elect continuation coverage within sixty (60) days after the date coverage would otherwise terminate, or the date notice of continuation rights was sent, whichever is later. Failure to timely notify NMD will abrogate the rights to continuation.

6. *Payment of Premium:* Any covered person receiving continuation coverage under this Section is responsible for the payment of any applicable premium. NMD or the employer's plan administrator will notify the covered person of his or her right to continue coverage under this Section, the amount, and method of payment to continue coverage and the date payments are due.

Section IV: *Services Covered by the Dental Plan*

The following services are payable in accordance with the Schedule of Dental Plan Benefits for Member or Non-Member Dentists, based on the usual and customary fees as established:

Coverage A: *Diagnostic and Preventative*

	Member Dentist	Non-Member Dentist
♦ Routine and Periodic Exams ➲	2 in 12-Month Period	6-Month Intervals
♦ Dental Prophylaxis ➲	2 in 12-Month Period	6-Month Intervals
♦ Bitewing X-rays ➲	12-Month Intervals	12-Month Intervals
♦ Full Mouth X-rays ➲	3-Year Intervals	3-Year Intervals

♦ Panoramic Films	➲	5-Year Intervals	5-Year Intervals
♦ Topical Fluoride Application	➲	12-Month Intervals	12-Month Intervals

Limitation: *Fluoride benefit is provided for covered dependents* **up to** *age 18.*

♦ Sealants	➲	5-Year Intervals	5-Year Intervals

Limitation: *Sealants are provided for permanent teeth only and for covered dependents* **up to** *age 18.*

♦ Oral Hygiene Instruction	➲	Once per Lifetime	Once per Lifetime

Coverage B: *Basic Restorative Services*

- Emergency treatment for the relief of pain.
- Amalgam, synthetic porcelain, plastic, and composite restorations.
- Routine oral surgery, including alveolectomy and pre and post-operative care.
- Endodontics, including pulpal therapy and root canal fillings.
- Non-surgical and surgical periodontics.
- All other oral surgery.
- Space maintainers for dependent children **up to** age seventeen (17).

Coverage B1: *Special Restorative Services*

- Special Restorative Services to restore lost tooth structure as a result of tooth decay or fracture including: *Crowns, jackets, pre-formed crowns, onlays or inlays when the tooth cannot be restored with another filling material.*

Limitation: *Benefit for the replacement of a crown, onlay or inlay will be provided only after a five (5) year period has elapsed.*

Crowns are payable for all teeth, pending approval by the Review Committee.

Coverage C: *Prosthetics*

- Bridges, partial and complete dentures, implants, and crowns when used as abutments to a bridge.
- Prosthetic repairs, adjustments, and relines to prosthetic appliances.

Limitation: *A given prosthetic appliance for the purpose of replacing an existing appliance will not be provided more than once in any five (5) year period, and then only in the event the the existing appliance is not, and cannot, be measured from the date on which the appliance was last supplied whether under this Dental Plan or not.*

The term "existing" is intended to include an appliance that was placed at the inception of the aforesaid five (5) year period, but which, for whatever reason, is no longer in the possession of the covered person.

Exclusion: *Coverage* **is not** *provided for the replacement of misplaced, lost, or stolen dental prosthetic appliances.*

Coverage D: *Orthodontics*

For treatment necessary for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies.

Limitation: *Orthodontics is subject to a lifetime maximum benefit payment as stated in the Schedule of Dental Plan Benefits and is provided for covered dependents between the ages of eight (8) and nineteen (19) unless otherwise specified by the employer.*

Coverage E: *TMJ (Temporomandibular Joint Dysfunction)*

- Charges necessary for the treatment of craniomandibular disorders and other conditions of the joint linking the jawbone and skull and the complex muscles, nerves, and other tissues related to the jaw joint.

Limitation: *TMJ benefit is subject to a lifetime maximum benefit payment as stated in the Schedule of Dental Plan Benefits.*

Exclusion: *Coverage* **is not** *provided for medical services rendered by a physician, hospital, or medical facility and* **is not** *in addition to benefits provided under Orthodontics.*

Section V: *Exclusions*

The following dental services and all associated expenses **are not** covered under this Dental Plan:

1. Services performed purely for cosmetic purposes or to correct congenital anomalies.
2. Services of general anesthesia, except when performed by a dentist or an employee of a dentist in his office, in conjunction with covered dental services.
3. Replacement of prosthetic or orthodontic appliances that are misplaced, lost, or stolen.
4. Charges for programs of treatment, prosthetics, or replacement of non-restorable teeth which were undertaken prior to the date the covered person became entitled to receive dental services under this Dental Plan.
5. Occupational accidents or sickness covered by Worker's Compensation.
6. Newer experimental dental techniques or procedures not approved by the American Dental Association.
7. Dental services which NMD is unable to provide because of any law or regulation of federal, state, or local government, or any action taken by any agency of federal, state, or local government.
8. Services performed by a member of the family, including one who usually resides in the same household with the covered person or one who is related by blood, marriage, or legal adoption to the covered person or to the covered person's spouse.
9. Veneers (*bonding of coverings to teeth*).

10. Orthodontic treatment procedures, unless specified in this Dental Plan as a covered dental benefit.

11. TMJ treatment procedures, unless specified in this Dental Plan as a covered dental benefit.

12. Surgery related to TMJ and osteotemies.

13. Charges in excess of the usual and customer fees as established.

14. Charges for any dental procedures or health services not specifically covered under this Dental Plan, to include hospital, physician, and prescription drug charges.

15. Charges for fluoride treatment for persons attaining age eighteen (18).

16. Charges for sealants for persons attaining age eighteen (18), and then only as provided in Section IV of this Dental Plan.

17. Charges for space maintainers for persons attaining age seventeen (17).

A person is fully responsible for all charges and expenses associated with dental care services and supplies not expressly covered by this Dental Plan.

Alternate Treatment Plans

In any case involving alternative treatment plans, the covered person and the dentist shall decide which treatment plan shall be implemented. NMD will be responsible for benefits payable only on applicable percentage of the least costly, commonly performed treatment. The covered person will be responsible for the balance of the treatment payment.

Section VI: *Emergency Care*

In the case of an emergency, a covered person may elect to obtain dental services from a Member or Non-Member Dentist. Dental services rendered by a Non-Member Dentist as follow-up to emergency dental services will be reimbursed pursuant to Section IV of this Dental Plan. The dental services covered by this Dental Plan in an emergency shall be limited to those dental services covered by this Dental Plan in a non-emergency.

A covered person shall notify NMD within ten (10) days of receipt of emergency dental services by a Non-Member Dentist. This notice must include the date the care was received, the name of the dentist, and a full description of the care provided.

Section VII: *Prior Authorization*

A prior authorization of cost with appropriate p.a. x-rays and narrative must be submitted to NMD for any dental treatment involving major restorative, periodontic, or orthodontic care.

This is to verify that the proposed treatment is covered by NMD dental benefits and to estimate the amount of payment.

Failure to submit a prior authorization of cost before the treatment is performed will result in the patient being responsible for payment of any dental treatment not approved by NMD.

Section VIII: *Reimbursement*

Dental Services Rendered by a Non-Member Dentist

A covered person is responsible for payment of the full amount of any bill submitted by a Non-Member Dentist. Written claims must be submitted to NMD within sixty (60) days of the date the covered person received the dental services from a Non-Member Dentist. Coverage for dental services received from a Non-Member Dentist may be denied or reduced if the covered person does not submit written proof of loss within sixty (60) days.

Dental Services Rendered by a Member Dentist

A Member Dentist shall not submit bills, claims, or claim forms to covered persons for dental services covered under this Dental Plan. A covered person shall pay all applicable co-payment charges directly to a Member Dentist at the time the services are rendered.

Section IX: *Deductible*

A covered person is responsible for the annual deductible, if any, as stated in the Schedule of Dental Plan Benefits. A family unit shall not be required to pay a total amount of more than three (3) deductibles. Coverage of eligible dental services begins when the covered person has incurred and submitted to NMD proof of payment of the deductible amount for dental services eligible for coverage under this agreement.

Section X: *Covered Fees*

Under this Dental Plan employees are free to go to the dentist of their choice. Payment is based on usual and customary fees. Amounts in excess of usual and customary fees are not considered eligible expenses by this Dental Plan.

Section XI: *Miscellaneous*

1. *Identification of Member Dentists:* NMD shall provide covered persons with a current list of Member Dentists, their addresses, and specialties. NMD shall periodically provide covered persons with notice of any changes in the list of Member Dentists.

2. *Entire Contract:* This agreement constitutes the entire Dental Plan offered by the employer with respect to the provision of dental services.

3. *Notices:* Any notice required to be given under this agreement shall be in writing. All notices shall be effective upon mailing, by first class mail, postage prepaid, to the address shown on the records of the employer. The covered person is responsible for providing the employer with correct address information.

4. *Dental Records:* A covered person shall authorize and direct, upon request by the employer or NMD the release to the employer or NMD of any and all dental records relating to an exam or treatment rendered to a covered person.

Section XII: *Coordination of Benefits*

1. *Coordination of Benefits:* If a covered person receives, is eligible, or is entitled to receive any benefit under any policy or plan of dental care, including, without limitation, any group or association dental insurance policies, group subscriber contracts, plans of self-insurance, pre-payment or contracts, or any group or individual no-fault automobile insurance contract, or any federal, state, or local government program providing dental benefits or the reimbursement of dental cost ("*Plan(s)*"), the coverage under all Plans shall be coordinated so that the total amount payable under all Plans shall not exceed 100% of any eligible expenses.

2. *Primary Responsibility:* Plans providing benefits or services pursuant to Worker's Compensation or similar laws, any Plan providing services or benefits under any no-fault automobile insurance act or similar law, or any federal, state, or local government program including Medicare, shall always have primary responsibility for the cost the dental services, unless precluded by law.

   Thereafter, primary responsibility for providing dental services or reimbursement for dental services shall be determined pursuant to the following rules or priority:

   (a) Plans that have no provision for coordination of benefits will pay claims before this Dental Plan.

   (b) Plans that cover a person other than as a dependent will pay claims before the Plan that covers a person as a dependent.

   (c) The Plan of the parent whose birth date comes first in the year shall be primary with respect to dependent children.

   (d) If (a), (b), and (c) do not establish primary responsibility, then the Plan that has covered the person for the longest period of time will pay claims first.

   Each covered person shall cooperate fully in assisting the employer and / or NMD in coordinating benefit plan responsibility pursuant to this Section.

Section XIII: *Subrogation*

Upon receipt of dental services under this Dental Plan, the covered person shall assign, transfer, and subrogate to the employer all of the covered person's rights of recovery against any third party. The employer may require an assignment of rights from the covered person to the extent of the reasonable value of services and benefits provided by NMD, plus the reasonable cost of collection.

The covered person shall cooperate with the employer in assisting it to protect its legal rights under these subrogation provisions and acknowledges that the employer's subrogation rights under this Section shall be considered as the first priority claim against any third party, to be paid before any other claims are paid, whether or not the covered person has been made whole or has recovered his or her total amount of damages.

In the event that the covered person shall be deemed to have been made whole by the settlement, and the employer shall be entitled to collect its subrogation rights as the first priority claim from the settlement fund. The covered person shall not prejudice the employer's rights under this provision, either before or after the need for services or benefits under this Dental Plan has elapsed. The employer may, at its option, collect such amounts from the proceeds of any settlement or judgement that may be recovered by a covered person or the covered person's legal representative.

Any proceeds of settlement or judgement shall be held in trust by the covered person for the benefit of the employer under these subrogation provisions, and the employer shall be entitled to recover reasonable attorney's fees from such covered person incurred in collecting proceeds held by the covered person.

The employer may assign any and all of its rights, duties, and responsibilities under this provision to NMD. In the event the employer assigns any rights, duties, and responsibilities hereunder, a covered person shall cooperate fully with NMD as fully as if NMD were the employer hereunder.

Section XIV: *Benefits Appeals Procedure*

1. *Filing of Claims:* When a claim for benefits is submitted to NMD, NMD will determine eligibility and have the amount of benefits payable determined, if any.

   In the event that NMD determines that no benefits are payable, the Administrative Manager of NMD shall give written notice to the covered person, dependents, beneficiaries, or authorized legal representative, as may be appropriate (*collectively referred to in the Benefits Appeals Procedure as "Participant"*). Whenever there has been a denial in whole or in part of such Participant's claim with respect to the eligibility for or amount of the benefit. Such notice shall include the following:

   (a) The specific reason or reasons for the denial.

   (b) Reference to pertinent provisions of the Dental Plan on which the denial was based.

   (c) A description of any additional material or information, if any, necessary for the Participant to perfect the claim, and, where appropriate, an explanation of why such material or information is necessary.

   (d) An explanation of NMD's Benefits Appeals Procedure.

2. *Request for Review:* Within sixty (60) days after the receipt by the Participant of the required notice, wherein the Participant's claim for benefits is denied in whole or in part, or if the Participant is otherwise dissatisfied with a determination of the Administrative Manager of NMD with respect to the eligibility for, or amount of benefit, the Participant may, in writing perform one of the following:

   (a) Request a review of such denial of such claim.

   (b) Request an inspection of designated, pertinent documents of files.

   (c) Submit issue and comments, as well as any additional or supplemental information or material that may have been requested in the notice of denial referred to in (a) or which the Participant may consider desirable or necessary.

   As part of such written request for review, a Participant may request a hearing, and in such event, the Participant (*or duly authorized representative of their choice*), shall be afforded an opportunity to appear before the Board of Directors, or at the Board's discretion, before a committee thereof.

No verbatim record of any such hearing or appearance need be made, but the Administrative Manager of NMD shall prepare a summary of the Participant's presentation and preserve the same, along with any documents that the Board of Director's, or any committee thereof, deem pertinent or which the Participant requests to have included in the file.

With respect to any matter which a Participant requests review in accordance with this Section, the Board of Directors, or a committee thereof, respectively shall act by the vote of a majority of its members present and shall notify the Participant of its decision:

(a) Within sixty (60) days after receipt, by the office of the Administrative Manager of NMD, of the written request for review in accordance with this Section is no hearing is requested in accordance with (b).

(b) Within one hundred twenty (120) days after receipt by the office of the Administrative Manager of NMD of the written request for review of the denial of the claim if a hearing is requested in accordance with this Section.

The decision of the Board of Directors, or a committee thereof, respectively, on review shall be in writing and shall include:

(a) Specific reasons for the decision.

(b) References to pertinent provisions of the Dental Plan on which the decision is based.

3. *Exhaustion of Administrative Remedies:* The procedure described in the Benefits Appeals Procedure must be followed and exhausted before any Participant may institute any legal action (*including actions or proceedings before administrative agencies*) with respect to a claim concerning the eligibility for, or amount of, benefits from and under this Dental Plan.