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# Dental Plan

## Dental Plan Highlights

<b>How to join</b>	You may enroll yourself and your <i>eligible dependents</i> when you are hired, within 31 days of a <i>life change event</i> or during annual open enrollment. You will need to complete an enrollment form listing yourself and any eligible dependents you want to enroll. Enrollment forms are available at <a href="http://my.harris.com/benefits-connection">my.harris.com/benefits-connection</a> or from the Harris Benefits Service Center by phone at 1 (321) 674-4275 (in Melbourne, FL, area) or 1 (800) 225-4343 (outside Melbourne) from 7:45 a.m. to 6 p.m. (Eastern Time) on business days, or through email at <a href="mailto:benefits@harris.com">benefits@harris.com</a> .
<b>Cost</b>	Harris pays the major portion of the cost of coverage. You contribute your share of the cost through pretax payroll deductions.
<b>When coverage begins</b>	Coverage begins on your hire date as long as you've completed and submitted your enrollment form to the Harris Benefits Service Center within 31 days of your hire date. If you enroll within 31 days following a <i>life change event</i> , your coverage goes into effect on the date of the event.
<b>Changing your election</b>	You can modify (add, change or cancel) your election during annual open enrollment or within 31 days of a <i>life change event</i> .
<b>Claim administrator</b>	MetLife Insurance Company
<b>For assistance</b>	Contact <i>MetLife</i> Customer Service at 1 (800) 942-0854, TDD: 1 (888) 638-4863, Monday through Thursday—8 a.m. to 11 p.m., Friday—8 a.m. to 5 p.m. (all times Eastern) or at <a href="https://mybenefits.metlife.com">https://mybenefits.metlife.com</a> .

# ABOUT THE HARRIS DENTAL PLAN

The Dental Plan is designed to help you maintain healthy teeth and gums by providing benefits for *preventive care*, *basic restorative care* and *major restorative care*. The Plan covers dental care expenses that the *claim administrator* determines to be necessary. Voluntary or elected treatment, except where specifically included by the Plan, is not covered.

This description of the Dental Plans, along with the separate “LifeLines” and “Benefit Administration” sections, comprises a complete summary plan description of your dental benefits as is required by the Employee Retirement Income Security Act of 1974 (ERISA).

## Terms You Should Know

Please refer to these “Terms You Should Know” to make sure you understand the italicized words and concepts found throughout this summary of the Harris Dental Plan.

- **Annual deductible**—Amount you must pay out-of-pocket for eligible *basic restorative care* and *major restorative care* before the Plan pays benefits for these types of services. The annual deductible is \$50 for an individual and \$100 for a family.
- **Annual limit**—Amount the Plan will pay for each covered individual for eligible dental services in each calendar year including *preventive care*, *basic restorative care* and *major restorative care*. Eligible expenses for *orthodontia* and *implants* are not applied to the annual limit.
- **Basic restorative care**—Services to correct tooth and gum problems such as fillings, extractions, periodontal work and root canals. Also included are repairs to inlays, crowns, bridges and dentures as well as relining or rebasing dentures.
- **Claim administrator**—Organization primarily responsible for managing Harris Dental Plan benefits. *MetLife* serves as the Plan’s claim administrator.
- **Eligible dependent**—Generally, your spouse, domestic partner and you and/or your domestic partner’s dependent children to age 19 who meet the full definition of “eligible dependent.” (See the separate “LifeLines” section of this summary plan description for a more complete definition.) If full-time student status is provided, eligibility for children can extend to age 25. Special eligibility provisions apply to mentally and physically disabled children.
- **Emergency care**—Treatment to relieve dental pain as well as treatment necessitated by an accident.
- **Implants**—The reconstruction of missing teeth and their supporting structures. Preapproval by *MetLife* is required.
- **Life change event**—Specific events defined by tax law that permit a change in your Dental Plan elections during a calendar year (e.g., legal change in your marital status, change in the number or eligibility of your dependents, etc.). (See the separate “LifeLines” section of this summary plan description for a more complete definition.)
- **Lifetime limits**—Amount the Dental Plan will pay for specific services during the entire period an individual is covered by the Dental Plan. The Plan’s lifetime limits apply to *orthodontia* (\$1,500), *temporomandibular joint disorders* (TMJ) (\$500) and *implants* (\$2,000).
- **Major restorative care**—Services to replace lost, diseased or damaged teeth including dentures, fixed bridge-work, crowns, inlays, onlays and implants. Also includes treatment for *TMJ*.
- **MetLife/MetLife Insurance Company**—The *claim administrator* for the Dental Plan. You can reach *MetLife* Customer Service at 1 (800) 942-0854, TDD: 1 (888) 638-4863, Monday through Thursday—8 a.m. to 11 p.m., Friday—8 a.m. to 5 p.m. (all times Eastern) or at <https://mybenefits.metlife.com>.
- **Network rate**—Prenegotiated cost that is generally lower than the “going rate” for similar services or supplies. Network rates are available if using *PDP* providers.
- **Orthodontia**—Braces and extractions to better align the teeth of participants under age 19.
- **Preferred Dentist Program (PDP)**—Option to use a network of dentists and take advantage of lower *network rates*. The PDP is provided automatically to Dental Plan participants.
- **Pretreatment review**—Recommended *claim administrator* review of any dental services that are expected to exceed \$150.



- **Preventive care**—Services aimed at preventing dental problems or catching them in their early stages. Included are services such as cleanings, x-rays, oral examinations, space maintainers and sealants.
- **Primary plan/primary coverage**—The plan that pays benefits first when a participant has coverage under more than one dental plan.
- **Reasonable and customary (R&C)**—The commonly charged or prevailing fees for dental services in a geographic area. A fee is considered to be reasonable and customary if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community as determined by the *claim administrator*.
- **Reimbursable charges**—If using a *PDP* provider, the *network rate*, if not using a *PDP* provider, the lower of the *R&C* charge or the provider's charge. The Plan pays a percentage of reimbursable charges for covered services.
- **Secondary plan/secondary coverage**—The plan that pays benefits second, if any are due, when a participant has coverage under more than one dental plan.
- **Temporomandibular joint disorders (TMJ)**—A group of symptoms that cause pain in the head, face and jaw. The symptoms include headache, soreness in the chewing muscles and clicking or stiffness of the joints. TMJ often has psychological as well as physical causes.

## How the Dental Plan Works

The Dental Plan is an optional benefit. If you enroll, you and each covered *eligible dependent* can receive up to \$1,500 in covered *preventive care*, *basic restorative care* and *major restorative care* each year. *Orthodontia* is also payable for covered children under age 19. Benefit levels vary with the type of service rendered and *lifetime limits* apply to certain types of services. In all cases, Plan benefits will be based on the lower of the provider's charge, the *network rate* (if applicable) or the *R&C* charge. In no case will the Plan pay more than the provider's charge.

### Enrolling in the Dental Plan

You can enroll yourself and your *eligible dependents* when you are hired, within 31 days of a *life change event* or during annual open enrollment. You will need to complete an enrollment form listing yourself and any eligible dependents you want to enroll. You cannot enroll your dependents in this Plan unless you are enrolled in it. Enrollment forms are available at [my.harris.com/benefits-connection](http://my.harris.com/benefits-connection) or from the Harris Benefits Service Center. Please note you will not receive an ID card for the Dental Plan.

You can also modify (add, change or cancel) your election during annual open enrollment or within 31 days of a life change event.

### Cost of Dental Coverage

You and Harris share the cost of dental coverage with Harris paying the major share. How much you actually pay is based on the level of coverage you select. To check the cost of dental coverage, go to the "Harris Benefits Calculator" at [my.harris.com/benefits-connection](http://my.harris.com/benefits-connection). Your Dental Plan premiums are paid with pretax dollars.

## Dental Plan Benefits

Dental Plan benefits are summarized below. Following the chart, you will find information on key plan features including:

- The **annual deductible** that must be met before most benefits begin
- The **Preferred Dentist Program (PDP)** that can provide dental care at less cost to you
- The **annual limit** that applies to most benefits and the **lifetime limit** that applies to certain covered expenses and
- **Pretreatment reviews** that provide a predetermination of your benefits before work begins.

## Dental Plan Benefits

Type of Covered Expense	Plan Payments	Special Notes
<b>Preventive care</b> (Cleanings, scalings and oral exams—up to two per year)	<ul style="list-style-type: none"> <li>• Plan pays 100%.<sup>1</sup></li> <li>• You pay 0%.<sup>1,2</sup></li> </ul>	No annual deductible is applied to preventive care. Expenses for preventive care apply to the annual limit of \$1,500 per participant as do expenses for basic and major restorative care.
<b>Basic restorative care</b> (Fillings, root canals, simple extractions, outpatient oral surgery, periodontal scalings, etc.)	<ul style="list-style-type: none"> <li>• Plan pays 80%.<sup>1</sup></li> <li>• You pay 20% after the deductible.<sup>1,2</sup></li> </ul>	Annual deductible is applied to basic and major restorative care: <ul style="list-style-type: none"> <li>• \$50/person</li> <li>• \$100/family.</li> </ul>
<b>Major restorative care</b> (Crowns, dentures, bridgework, etc.)	<ul style="list-style-type: none"> <li>• Plan pays 50%.<sup>1</sup></li> <li>• You pay 50% after the deductible.<sup>1,2</sup></li> </ul>	Annual limit of \$1,500 per participant applies to basic and major restorative care (other than <i>implants</i> that has its own \$2,000 <i>lifetime limit</i> ) as well as preventive care. You pay any amounts not covered by the Plan.
<b>Orthodontia for children</b> (For each dependent child under age 19)	<ul style="list-style-type: none"> <li>• Plan pays 50%.<sup>1</sup></li> <li>• You pay 50%.<sup>1,2</sup></li> </ul>	\$1,500 lifetime limit per child, no annual deductible is applied. Expenses do not apply to annual limit. You pay any amounts not covered by the Plan.

<sup>1</sup> If using a PDP provider, benefits are based on network rates. If not using a PDP provider, benefits are based on the amount that is lower: the R&C charge or the provider's charge. In no case will the Plan pay more than the provider's charge.

<sup>2</sup> You will pay more if your expenses exceed allowable reimbursable charges, the annual limit or lifetime limits or are deemed not necessary by the claim administrator.

### Annual Deductible

Before the Plan pays its part of the cost for covered *basic restorative care* or *major restorative care*, an *annual deductible* must be met. This deductible is \$50 for an individual and \$100 for a family. Once the family deductible has been satisfied, the Plan will pay benefits at the applicable benefit level for all covered dependents for the remainder of the calendar year. To meet the family deductible, you and your covered dependents must have \$100 in any combination of covered dental treatment expenses; however, no more than \$50 will be counted for any one family member toward the family deductible. No deductible is applied to *preventive care*, *orthodontia* or *emergency care*. (See “Emergency Treatment” later in this section of the summary plan description for more about emergency coverage.)

### Preferred Dentist Program (PDP)

The Dental Plan offers a valuable option—the *Preferred Dentist Program (PDP)*. As a Dental Plan participant, you are automatically enrolled in this program. The PDP gives you the option of using an in-network or out-of-network dental provider each time you receive service. When you use a PDP network dentist or dental specialist, you will be charged lower *network rates* for the dental service and your out-of-pocket costs will generally be less than if you use a non-network provider.

Network providers must meet the *claim administrator's* standards for education, licensing and practice history in order to participate in the network. These providers have agreed to be subject to reviews of the services they deliver to help ensure that you're getting the quality of care you want for yourself and your family.

Provider listings are available through *MetLife* Customer Service or at <https://mybenefits.metlife.com>.

### Benefit Limits

The Plan has an *annual limit* and *lifetime limits* that apply to Plan payments. Keep these limits in mind since, once met, they will impact the payment of benefits under the Plan.

### Annual Limit

There is an *annual limit* that applies to *preventive care*, *basic restorative care* and *major restorative care*. It is \$1,500 in benefits for each covered person in each calendar year. Once you or a dependent reaches this limit, the Plan will no longer pay benefits for services for that person for the remainder of that calendar year. The annual limit does not apply to *orthodontia* or *implants*.

## Lifetime Limits

There are *lifetime limits* that apply to the following services:

- **Orthodontia**—Up to \$1,500 in lifetime benefits for each covered child up to age 19.
- **Implants**—Up to \$2,000 in lifetime benefits for each person.
- **Temporomandibular joint (TMJ) disorders and necessary orthodontic or orthopedic appliances**—Up to \$500 in outpatient lifetime benefits per person.

Orthodontia and implants are not subject to the *annual limit* in addition to their respective lifetime limits. Both the annual and lifetime limits apply to *TMJ* treatment.

## Pretreatment Review

When you need dental treatment that will cost over \$150, you should consider having a *pretreatment review* by the *claim administrator*. To do so, your dentist must complete and submit a claim form to the claim administrator in advance of the treatment. This way, you'll know if the claim administrator agrees with your dentist's treatment plan and what will be covered. And, you'll know how much the Plan will pay before you incur any expenses.

## Alternative Treatment

The *claim administrator* reserves the right to pay benefits based on what it feels is recognized as necessary and acceptable treatment. Thus, the claim administrator may deem that a lower-cost alternative is just as effective as the treatment your dentist has provided or is recommending. In such situations, your reimbursements will be based on the *R&C* amount for that lower cost treatment.

If you have a *pretreatment review*, you'll know if the claim administrator is recommending an alternative treatment approach in advance. Then, you can decide whether or not you want to pursue the higher-cost treatment. If you do, you will be fully responsible for your share of the *R&C* cost of the method recommended by the claim administrator plus any additional costs for the treatment you've selected. If you don't file a pretreatment review, you run the risk of being surprised by a larger than expected out-of-pocket expense.

## What Is Covered

Benefits are paid only for covered dental care performed by a licensed dentist or dental hygienist working within the scope of his/her license. The services or supplies you receive must be necessary for the treatment of a dental condition or for *preventive care*, and rendered in accordance with professionally recognized standards of dental practice. The *claim administrator* bases benefits on the following:

- The *network rate*, if using a *PDP* provider or
- The lower of the *R&C* rate or the provider's charge, if not using a *PDP* provider.

In no case will the Plan pay more than the provider's charge.

Following you will find information about the types of dental services and supplies that are covered by the Dental Plan and the level of coverage for each. Bear in mind, total payments from the Dental Plan each year (for other than *orthodontia* and *implants*) are subject to the \$1,500 *annual limit*. Once the annual limit is reached, expenses subject to that limit are not paid by the Plan for the remainder of the calendar year.

## Preventive Care

*Preventive care* is provided each calendar year for you and your covered dependents as follows:

- Two routine oral exams
- Two cleanings and scalings
- Two sets of partial x-rays for teeth in the jaw area (bite wings) for children under age 19
- One set of partial x-rays for teeth in the jaw area (bite wings) for adults
- One fluoride treatment for children up to age 19
- Sealants for nondecayed, nonrestored, permanent first and second molars for children under age 15 (limited to one application in a 36-month period) and
- Space maintainers.

The Plan also pays for one set of full mouth x-rays every 60 consecutive months.

All of these services and supplies are paid at 100% of *reimbursable charges* without the *annual deductible* applied. These services are subject to the \$1,500 *annual limit*.

## Basic Restorative Care

*Basic restorative care* is covered for services including:

- Fillings and extractions
- Periodontics, including treatment for gum and mouth tissues
- Endodontics, including root canals
- Dentist's antibiotic injections
- Outpatient oral surgery, including lab and x-ray services
- Recementing and repairing inlays, crowns, bridges and dentures
- Relining or rebasing dentures—once every 36 months (must be more than 6 months after installation).

Once the *annual deductible* is met, these services and supplies are paid at 80% of *reimbursable charges*, subject to the \$1,500 *annual limit*.

## Oral Surgery

Outpatient oral surgery is covered the same as *basic restorative care*. Oral surgery includes:

- Surgical extractions
- Incision and drainage of an abscess
- Biopsy of oral tissue
- Periodontal oral surgical procedures such as gingivectomy and osseous surgery.

Once the *annual deductible* is met, these services are paid at 80% of *reimbursable charges*, until you reach your \$1,500 *annual limit*.

Oral surgery performed in a hospital or a surgery center may be covered by your medical benefits, if elected. It is advisable to check with your medical benefit claim administrator to determine if the treatment will be covered by your medical benefits.

## Major Restorative Care

*Major restorative care* is covered for the following more extensive dental services:

- **Crowns, inlays, onlays or gold fillings**—Restorative services for a diseased or fractured tooth, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, acrylic or composite filling restoration.
- **Fixed bridgework and denture installation**—Initial installation of fixed bridgework or dentures to replace a tooth or teeth lost after the effective date of coverage.
- **Fixed bridgework and denture replacement**—Replacement of full or partial dentures, fixed bridgework or adding teeth to any of these as long as any of the following apply:
  - The teeth being replaced or added are necessary because a tooth was extracted after the dentures or bridgework were put in.
  - The existing dentures or bridgework are at least 60 months old and can't be repaired.
  - The dentures you have now are temporary and can't be made to work permanently. (In this case, the permanent dentures must be put in within 12 months after you received the temporary ones to be paid by the Plan.)
- **Implants**—Restorative implant, \$2,000 *lifetime limit* per person. The *annual limit* is not applied to implants.
- **Temporomandibular joint (TMJ) disorders**—Treatment including necessary orthodontic or orthopedic appliances—up to a \$500 *lifetime limit* per person. (Sometimes, medically necessary TMJ surgery performed in a hospital or at a surgery center is covered by your medical benefits. Contact your medical benefit claim administrator for additional information.)

Once the *annual deductible* is met, these services and supplies are paid at 50% of *reimbursable charges*, until you reach any applicable annual or lifetime limits.



## Emergency Treatment

Emergency treatment to relieve dental pain (including lab and x-rays) is paid at 100% of *reimbursable charges* if you don't receive any other dental care on the day you seek *emergency care*. The *annual deductible* is not applied. Emergency treatment is subject to the \$1,500 *annual limit*. Facility charges may be paid under your medical coverage. Check with your medical benefit claim administrator.

## Orthodontia

Orthodontic services for braces or necessary extractions related to braces are covered for each enrolled dependent child under age 19. The Plan pays 50% of *reimbursable charges*, up to a \$1,500 *lifetime limit* per child. You do not have to meet the *annual deductible* before the Plan pays orthodontic benefits. Also, the \$1,500 *annual limit* does not apply. Orthodontic benefits are paid on a pro rata basis each month over the term of the contract for the orthodontic services. Please call the *claim administrator* if you have questions regarding how the Plan will pay these benefits.

## What's Not Covered

The Plan covers a wide range of expenses, but it does not cover all dental service expenses. The list below briefly describes typical charges that the Dental Plan doesn't cover. To be certain of the benefits payable under the Plan, request a *pretreatment review* by the *claim administrator*.

- Dental care paid by a Harris-sponsored medical plan (e.g., inpatient oral surgery and certain accident-related dental treatment)
- Dental care you're eligible for by law or from a government program or institution
- Services and supplies not provided by a licensed dentist, physician or licensed dental hygienist under the dentist's supervision
- Services and supplies for treatment of a job-related injury or illness that is usually covered by workers' compensation and other laws
- Care you receive and don't have to pay for
- Care to treat a disease or injury caused by war or any acts of war
- Replacement of teeth that are missing and unreplaced when coverage goes into effect unless necessary because of a congenital anomaly of a dependent child
- Dental care that you have before coverage starts or after coverage ends—unless your dentist orders crowns, inlays, dentures or bridges before coverage ends and you receive them within 30 days of the date coverage ends
- Unnecessary or experimental/investigational services and supplies, dental care that's not recommended by your dentist or ordered by a licensed dentist or dental expenses above approved reimbursement rates for your location
- Care to alter vertical dimension, restore occlusion or stabilize a periodontic problem
- Services for cosmetic dental work or cosmetic oral surgery, including personalization or characterization of dentures
- *Orthodontia* care for covered individuals age 19 and over
- Charges for missed dental appointments or for filling out your claim form
- Replacement of lost or stolen dentures
- Veneers or similar coverings added to crowns and pontics for any teeth except the upper and lower 10 front teeth
- Temporization for certain procedures (e.g., dentures)
- Services and supplies that are not specifically listed as part of covered care (see "What Is Covered," earlier in this section of the summary plan description)
- Appliances (fixed and removable) for the correction of harmful habits
- Fees for services not approved by the claim administrator.

## Filing a Claim

MetLife serves as the *claim administrator* for the Dental Plan. After you receive services, you'll need to file a claim form with the claim administrator to be reimbursed—unless you use a *PDP* provider who will file the claim for you. Both you and your provider will need to complete information on the form, so you should bring a claim form with you when you receive services. Claim forms are available through MetLife Customer Service or at <https://mybenefits.metlife.com> or at [my.harris.com/benefits-connection](http://my.harris.com/benefits-connection). Forms should be submitted to:

MetLife Dental Claims  
P.O. Box 981282  
El Paso, TX 79998-1282

You can have the benefits paid directly to your dentist or, if you prefer, you can pay the dentist and have the reimbursement check sent directly to you. Be sure to submit claims promptly. The claim administrator has the right to deny claims submitted more than 1 year from the treatment date.

### Explanation of Benefits (EOB)

You will receive an explanation of benefits (EOB) if you have any patient responsibility toward payment of the claim. You will not receive an EOB if the dental services are covered in full and benefits have been assigned to the dentist. (This is typically the case for routine visits for *preventive care* covered at 100% of *reimbursable charges*.) You may view and print your claims at <https://mybenefits.metlife.com> regardless of amount of patient responsibility.

If the network provider's statement shows that you owe more than the amount shown on the EOB, contact the *claim administrator*. This type of charging is called "balance billing" and isn't allowed when you access care through a network provider.

### Time Frame for Making a Claim Determination

After your Dental Plan claim is submitted, the *claim administrator* will ordinarily notify you of its benefit determination—adverse or not—within a specific time frame. The time frame differs depending on whether you've submitted an urgent care claim, a preservice claim or a post-service claim:

- **Urgent care claim**—You will receive a benefit determination within 72 hours after receipt of the claim. (A decision may be provided to you orally, as long as written or electronic notification is provided to you within 3 days after the oral notification.) To be considered an urgent care claim, an individual acting on behalf of the claim administrator, applying the judgment of a prudent layperson, will determine if your claim can be considered as such. However, if a dentist with knowledge of your condition determines that the claim involves urgent care, it must be considered an urgent care claim.
- **Preservice claim**—You will receive a benefit determination within 15 days after receipt of your request for pre-termination of dental benefits.
- **Post-service claim**—The claim administrator will notify you of any denial of your claim within 30 days after receipt of your claim for dental care that you've already received.

### Statute of Limitations for Claim Submission

The *claim administrator* reserves the right to deny claims that are submitted more than 1 year from the date of treatment.

### When a Claim Is Denied

Regardless of the type of claim, you will receive a notice of any claim denial that includes:

- The specific reason(s) for the denial and, if a claim is denied as a covered dental service or for being experimental in nature, either the scientific or clinical reasons why the determination was made or the option to obtain this information free of charge.
- References to the pertinent Dental Plan provisions on which the decision is based.
- A description of any additional material or information needed to support your claim.
- A description of the Dental Plan's claim review procedure and the time limits applicable to such procedure (including your legal rights if a claim is denied).
- References to any internal rule, guideline or protocol relied upon in making the decision.
- A description of the expedited review process applicable to the claim for denied urgent care claims.



## What Happens if You Don't Follow Required Procedures

For urgent care and preservice claims, if you fail to provide the *claim administrator* with sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, or if you fail to follow the Dental Plan's procedures for filing your claims, the claim administrator must notify you within 24 hours of receiving your urgent care claim or within 5 days of receiving your preservice claim of the specific information needed to complete the claim. Notification may be oral, unless you request written notification. In the case of an urgent care claim, you then have 48 hours to provide the information needed to process the claim. You will be notified of a determination on your urgent care claim no later than 48 hours after the earlier of:

- The claim administrator's receipt of the requested information or
- The end of the 48-hour period within which you were to provide the additional information.

## Extension Periods for Deciding Dental Plan Claims

For preservice and post-service claims, a 15-day extension of the time period for deciding claims may be allowed, provided that the *claim administrator* determines that the extension is necessary due to matters beyond its control. If such an extension is necessary, the claim administrator must notify you before the end of the original 15-day period of the reason(s) requiring the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must also specifically describe the required information. You then have 45 days to provide the information needed to process your claim. If you do not provide the required information within the 45-day period, your claim may be denied. If an extension is necessary for preservice and post-service claims due to your failure to submit necessary information, the plan's time frame for making a benefit determination is stopped from the date the claim administrator sends you an extension notification until the date you respond to the request for additional information.

## Appeals

If you feel that you are eligible for benefits and you've been denied these benefits, you can appeal the *claim administrator's* decision. The appeals process is described in detail in the separate "Benefit Administration" section of this summary plan description under the headings "Authorization of Health Care Services" and "Appeals."

## Coordination of Benefits

If you and/or a family member are covered by another dental plan or insurance, there may be some duplication of the benefits provided by your Harris-sponsored plan and your other coverage. When this occurs, your benefits under the Harris Dental Plan will be coordinated with benefits payable under the other plan.

## Primary and Secondary Coverage

In determining how the plans coordinate benefits, one plan is considered the *primary plan* and the other is considered the *secondary plan*. The primary plan pays benefits first, up to the limit of that plan. The secondary plan will not pay benefits until the primary plan pays or denies a claim.

When the Harris Dental Plan is considered "primary," it pays benefits first. The other coverage is "secondary" and pays benefits, if any, in accordance with its plan provisions. If you have a spouse working at Harris, he/she can't cover you under the Harris Dental Plan and also be covered as a family member under the Harris Dental Plan. An employee cannot carry single Harris coverage and also be covered as a dependent with Harris coverage.

## How Primary Coverage Is Determined

*Primary coverage* is determined differently in different circumstances as follows:

- **If you have dual coverage**—If you are an active employee and covered by the Harris Plan and another group plan, the Harris Plan is considered your *primary coverage*. As your primary coverage, the Harris Plan pays or denies your claim first. Once the Harris Plan has made its benefit determination, you can submit the claim to the *secondary plan* for reimbursement of any unpaid amounts under its provisions. If you are not actively working, the Harris Plan is considered your primary plan when coordinating with a spouse's employer-sponsored plan.
- **If you have coverage from Harris and a former employer**—If you have coverage from a current and a former employer, the current employer's plan is your *primary coverage*. Where the preceding rules don't resolve which plan is primary, the plan covering the person longer is primary. But, if one or the other plan doesn't have a provision to coordinate payments, that plan will pay first.

- **If you or a dependent have automobile insurance**—If you or a dependent have automobile insurance coverage, no fault and otherwise, where permitted by law, that coverage shall be primary to the coverage afforded by the Harris Plan, regardless of the individual's election under PIP (Personal Injury Protection) coverage with the automobile insurance carrier.
- **If your spouse has dual group coverage**—When enrolled in both the Harris Dental Plan and his/her employer's group plan, your spouse's *primary coverage* will be his/her employer's plan with *secondary coverage* under the Harris Plan. After the primary plan pays or denies a claim, your spouse can submit the claim to the Harris Plan.
- **If your dependent children have dual coverage**—If your child is covered by both your and your spouse's employer-sponsored plans, then the "birthday rule" determines which plan will be the child's *primary plan*. Under the birthday rule, the plan of the parent whose birthday falls earliest in the calendar year is your child's primary plan. If both parents have the same birthday, the parent who has been covered longer has the primary plan. If your spouse's plan doesn't follow the birthday rule, then the father's plan is primary.
- **If you're divorced and have children with dual coverage**—If you are divorced or separated and a court decree establishes financial responsibility for the dental care of a child, the plan of the parent assigned that responsibility will be that child's *primary plan*. In the absence of a court decree and when both parents have not remarried, the plan of the parent with custody will pay benefits before the plan of the other parent. If the parent with custody has remarried and the plan of the custodial parent's spouse also covers the child, the plan of the parent with custody will pay first, the plan of the custodial parent's spouse will pay next and the plan of the parent without custody will pay last.

## Benefits When Coverage Is Secondary

When the Harris Dental Plan provides *secondary coverage*, all Plan rules apply for reimbursement. Here's how the Plan pays benefits when the Dental Plan is the *secondary plan*. The *claim administrator* determines the benefit that would be paid if it were the only plan. This includes applying the appropriate *annual deductible*, if any, and all other benefit limits. The amount of benefit paid by the *primary plan* is subtracted from any benefit that would be paid by the Harris Dental Plan. This means that when the Harris plan is secondary, it will only pay the difference, if any, between its usual benefit and the benefit eligible to be paid by the primary plan.

## When Coverage Can Change or End

### Changes in Coverage

Once you make your Dental Plan coverage elections for the year, you generally will not be able to change such elections until the next annual open enrollment period. You may, however, be able to change your elections during the year if a *life change event* occurs, and your election change is consistent with the life change event. You must request the change in your Dental Plan election within 31 days of the event by submitting a benefits change form to the Harris Benefits Service Center. Coverage is retroactive to the date of the event.

### When Coverage Ends

Your Dental Plan coverage ends in any of these circumstances:

- Your employment ends (unless you're eligible for continuing coverage as is described below)
- You or a family member loses eligibility
- You elect to discontinue participation or don't pay the required premiums or contributions
- You die or retire (unless retiree coverage is available and elected)
- The Plan ends.

Your Dental Plan benefits may also be changed or ended or the cost of coverage changed if you have received an overpayment of Long-Term Disability Plan benefits and refuse to enter into an acceptable repayment plan or fail to adhere to a repayment plan to which you have agreed. Any decision in this regard will be made in the discretion of the plan administrator (or its designee).



## Your Dependents' Coverage

Dental coverage for your covered *eligible dependents* ends when your coverage ends or when your dependents no longer meet the Plan's definition of eligibility, whichever occurs first. An exception is made when covered dependents are eligible for retiree coverage. Extended coverage may be available under COBRA. (See "Continuing Coverage and COBRA" below.)

## Continuing Coverage and COBRA

In some cases, your dental coverage may continue even though you are no longer at work. If you had dental coverage on your last day of work and continue to pay the active employee rate, you can continue your current level of coverage under the following circumstances:

- You are on an approved leave of absence. (Benefits can continue for up to 3 months for most leaves. For military leaves, benefits can continue for up to 12 months, or longer, at management discretion.)
- You are receiving Short-Term Disability Plan or Long-Term Disability Plan benefits from Harris. (If you discontinue dental coverage, you cannot re-enroll until you return to active employment.)
- You are receiving periodic payments under the Severance Pay Plan.
- You are eligible for coverage as a retiree. (See "When You Retire" next in this section of the summary plan description.)

Under most circumstances, COBRA continuation coverage is available to extend coverage for those individuals covered at the time of the loss of coverage. (See the separate "Benefit Administration" section of this summary plan description for more information on COBRA.)

## When You Retire

When you retire from employment with Harris, you may continue dental coverage if you're at least age 55 with 10 years of service. Harris reserves the right to, at any time, change dental coverage, discontinue offering it to retirees, adjust required payments periodically or offer benefits different from those that are available to active employees.

## Electing To Continue Coverage After Retirement

If you continue coverage after retirement, you'll pay the full cost and all of the following will apply:

- You must continue coverage for yourself in order to cover any *eligible dependents*
- You may continue coverage for yourself and any eligible dependents who were covered before you retired
- Your spouse may continue coverage after your death for life or until remarriage
- Your dependent children may continue coverage after your death as long as they meet the Plan's definition of eligible dependent.

## Declining Coverage After Retirement

If you decline to continue coverage when you retire or if you discontinue coverage at any time after initially electing it, you won't be able to re-enroll at a later date.

## Use and Disclosure of Health Information

Please refer to the "Benefit Administration" section of this summary plan description for information about the use and disclosure of your protected health information as related to the Dental Plan and other Harris health plans.

## The Harris Benefits Service Center

### For More Information on Plan Provisions and Administration

#### To reach by phone

- Hours open 7:45 a.m. to 6:00 p.m. (Eastern Time) business days
- Number to call in Melbourne, FL 1 (321) 674-4275, option 1
- Call from outside Melbourne, FL 1 (800) 225-4343, option 1

#### To reach by mail

Harris Benefits Service Center  
Mail Stop C-411  
1025 W. NASA Blvd.  
Melbourne, FL 32919

#### To reach by fax

1 (321) 674-4285

#### To reach by email

[benefits@harris.com](mailto:benefits@harris.com)

