# Avnet, Inc. Dental Plan

## Avnet, Inc.

## MetLife Preferred Dentist Program

PPO Dental and Copay Dental

Effective Date: January 1, 2019

Group Number: 305519

# Important Information

This booklet serves as both the plan document and summary plan description for the Avnet, Inc. PPO Dental Plan and Copay Dental Plan (the "Plan"), which is offered as an option under the Avnet Group Benefits Plan. The plan is a self-funded dental benefit plan provided by the Employer and is effective as of January 1, 2019.

Metropolitan Life Insurance Company ("MetLife") does not insure the benefits described in this booklet. Claims are administered on behalf of this Plan by MetLife as the Claims Administrator pursuant to the terms of an administrative services agreement.

Please review this booklet carefully to become familiar with your benefits. You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined in the Definitions section of this booklet. However, other terms are defined in the section of this booklet where they are primarily used.

## Plan Does Not Create a Contract of Employment

Nothing contained in this document shall be construed as a contract of employment between Avnet (the "Company" or the "Employer") or any of its subsidiaries, and any Employee or other individual, nor as any limitation of the Company's right to discipline, discharge, or take action with respect to any Employee or other service provider, with or without cause, at any time, or otherwise limit the employment-at-will relationship between the Company and an Employee or other service provider.

## Schedule of Benefits

For the PPO Dental option, the Schedule of Benefits is a brief outline of your maximum benefits that may be payable under your Plan coverage. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

For the Copay Dental option, the Schedule of Benefits is a brief outline of your maximum benefits that may be payable under your Plan coverage. For the applicable Copayment for each service, refer to the copay schedule and accompanying geographic location chart.

Your Dental Benefits

The Avnet Inc. Dental Plan gives you access to Dentists through the MetLife Preferred Dentist Program. You are always free to receive services from any Dentist, and you do not need any authorization from this Plan to choose a Dentist. However, as explained in this booklet, you may be able to reduce your out-of-pocket costs by using a PDP or PDP Plus Network Dentist, because:

- Network Dentists have agreed to limit their charges for dental services (e.g., in the PPO Dental option to the Maximum Allowed Charge). In contrast, Out-of-Network Dentists have not entered into agreements to limit their charges;
- In the PPO Dental option, the Plan covers a percentage of the Maximum Allowed Charge for Network Dentists. In contrast, for Out-of-Network Dentists, the Plan covers only a percentage of the Reasonable and Customary Charge. You are responsible for 100% of any excess over the Reasonable and Customary Charge (in addition to a percentage of the Reasonable and Customary Charge); and
- In the Copay Dental option, reimbursements for Covered Services provided by an Out-of-Network Dentist are subject to a deductible that does not apply for Covered Services performed by a Network Dentist. In addition, The Plan generally pays a higher benefit amount for Covered Services provided by a Network Dentist than for Covered Services provided by an Out-of-Network Dentist.

The Preferred Dentist Program does not provide dental services or determine whether you should or should not receive any service. You and your Dentist have the right and are solely responsible at all times for choosing the course of treatment and services to be performed. Determinations by the Claims Administrator relate only to whether and how much the Plan will pay for treatments and services that you elect to receive after consulting with your Dentist.

When requesting a Covered Service from a Network Dentist, it is recommended that you:

- identify yourself as covered in the Preferred Dentist Program; and
- confirm that the Dentist is currently a PDP and/or PDP Plus Network Dentist at the time that the Covered Service is performed.

You can obtain a listing of MetLife's Network Dentists either by calling 800-942-0854 or by visiting MetLife's website at www.metlife.com/dental.

## Filing Dental Claims

If you or a Dependent incur a charge for a Covered Service, Proof of the service must be sent to the Claims Administrator for review and processing. See "Procedures for Initial Claim" section for additional information.

In general, you should give the Claims Administrator Proof of the claim as soon as you have incurred covered expenses and have received an itemized bill from your Dentist. **The deadline for providing Proof for payment of covered dental benefits is 90 days after the service starts.** If Proof is not filed within 90 days, the claim will be invalidated or reduced unless you can show that the claim was filed as soon as was reasonably possible.

## Physical Examination

The Company, at its own expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require.

# Eligibility to Participate in the Plan

## Eligibility for Employee Plan Coverage

You will become eligible for Plan coverage on the day you complete the waiting period if you are a regular Employee of the Employer who works an average of at least 20 hours per week.

In order to participate in the Plan, you must be employed by a participating business unit of the Employer. Most of the Employer's business units based in the United States participate in the Plan. However, certain business units do not. For more information, please contact the Avnet Benefits Department at 888-99-HR NOW (888-994-7669).

## Eligibility for Dependent Coverage

You will become eligible for Dependent coverage on the later of the day you become eligible for yourself or the day you acquire your first Dependent.

## Waiting Period

You are eligible for coverage on the first day of the month after your date of hire. The waiting period applies only for new hires and people who are rehired more than six months after they last worked for the Company. You will not be required to satisfy the waiting period if (a) you have not terminated employment with the Company (e.g., you lose coverage as a result of having your hours reduced to less than 20 hours per week and later return to an eligible position without having terminated employment); or (b) you are rehired as an eligible Employee within six months after terminating your employment.

## Employee Plan Coverage

The Plan is offered to you as an Employee. To be covered, you must enroll and you will have to pay part of the cost.

## Effective Date of Plan Coverage

You can make an initial election to enroll in the Plan at any time during the first 30 days after you are hired into an eligible position. If you enroll during this initial enrollment period, your participation (and that of your Dependents, if elected) will be effective as soon as you are eligible to participate in the Plan.

You will not be denied enrollment for Plan coverage due to your health status.

In order to become covered on your first day of eligibility, you must be in Active Service on that date, unless the reason for not being in Active Service is due to your health status.

If you do not enroll during the initial enrollment period above, you will not be allowed to enroll until the next open enrollment period, except to the extent that the rules under “Changing Your Coverage Elections,” below, allow a mid-year change.

## Dependent Plan Coverage

For your Dependents to be covered, you will have to pay the required contribution toward the cost of Dependent coverage.

## Effective Date of Dependent Coverage

Coverage for your Dependents will become effective on the date you enroll in the Plan, but no earlier than the day you become eligible for Dependent coverage. Your Dependents can be covered only if you are covered.

# PPO Dental

| Schedule of Benefits |
| --- |
| **For You and Your Dependents**<br>The Plan includes Network and Out-of-Network Dentists. If you select a PDP or PDP Plus Network Dentist, your cost will generally be less than if you select an Out-of-Network Dentist. |
| **Deductibles**<br>The Deductible is the amount that you or your Dependent must pay for a Covered Service provided by a Network or Out-of-Network Dentist to which such Deductible applies each Year before this Plan will pay benefits for such service. This Plan applies amounts used to satisfy the Yearly individual Deductible to the Yearly family Deductible. Once the Yearly family Deductible is satisfied, no further Yearly individual Deductibles are required to be met. |
| **Network Dentist Payment**<br>A Covered Service provided by a Network Dentist is paid based on a percentage of the Maximum Allowed Charge that Network Dentists agree to (minus the applicable Deductible for Type B and C services).<br>**Out-of-Network Dentist Payment**<br>A Covered Service provided by an Out-of-Network Dentist is paid based on a percentage of the Reasonable and Customary Charge (minus the applicable Deductible for Type B and C services). |

| PPO DENTAL BENEFIT HIGHLIGHTS | NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| Types A, B and C Combined Calendar Year Maximum | $2,000 | $2,000 |
| Type D Lifetime Maximum | $1,500 | $1,500 |
| Calendar Year Deductible<br>Individual (Type B and C)<br>Family Maximum (Type B and C) | <br>$50<br>$150 | <br>$50<br>$150 |
| Type A<br>Preventive/Diagnostic Care | 100% | 100% |
| Type B<br>Basic Restorative | 80% | 80% |
| Type C<br>Major Restorative | 50% | 50% |
| Type D<br>Orthodontic | 50% | 50% |

# PPO Dental – Covered Services

The Plan covers a portion of a Dentist's charge for Covered Services delivered to a Participant. To be a Covered Service, all of the following conditions must be satisfied:

- the service must be ordered or prescribed by a Dentist;
- the service must be Dentally Necessary; and
- the service must be within the scope of the Plan's coverage limitations.

The Plan will pay a portion of a Dentist's charge for a Covered Service (as set forth on the Schedule of Benefits) only if the following conditions are satisfied:

- the Deductible amount, if applicable, in the Schedule of Benefits has been met;
- the maximum benefit in the Schedule of Benefits has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefits provision; and
- for Type A, B or C covered services the service is started and completed while coverage is in effect.

The following section lists covered dental services. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to MetLife.

## Type A – Preventive and Diagnostic Covered Services

1. Oral exams twice in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), twice in a Year.
4. Problem-focused exams.
5. Full mouth or panoramic x-rays once every 5 Years.
6. Bitewing x-rays 2 sets in a Year.
7. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
8. Diagnostic casts.
9. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderage or severe gingival inflammation after oral evaluation) three times in a Year.
10. Emergency palliative treatment to relieve tooth pain.
11. Topical fluoride treatment for a Child under age 19, once in a Year.
12. Space maintainers for a child under age 19.
13. Sealants for a Child under age 19 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.
14. Full mouth debridements, but not more than once in any 3-Year period.
15. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed. Periodontal maintenance is limited to two times in any Year.
16. Intraoral-periapical x-rays.

17. X-rays, except as mentioned elsewhere.
18. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.

## Type B – Basic Covered Services

1. Amalgam fillings.
2. Resin-based composite fillings.
3. Oral surgery, except as mentioned elsewhere in this summary plan description.
4. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12-month period.
5. Other consultations, but not more than twice in a 12-month period.
6. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surger.
7. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
8. Periodontal scaling and root planing, but not more than once per quadrant in any 24-month period.
9. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period.
10. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
11. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
12. Pulp capping (excluding final restoration).
13. Therapeutic pulpotomy (excluding final restoration).
14. Pulp therapy.
15. Pulpal regeneration, but not more than once per lifetime.
16. Apexification/recalcification.
17. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claims Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
18. Injections of therapeutic drugs.
19. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36-month period.
20. Recementing of Cast Restorations or Dentures.
21. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12-month period.
22. Addition of teeth to a partial removable Denture.
23. Tissue conditioning, but not more than once in a 36-month period.
24. Simple repairs of Cast Restorations or Dentures other than recementing.
25. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 3 Years.

26. Interim caries arresting medicament application applied to permanent bicuspids and first and second molar teeth, once per tooth every 3 Years
27. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.
28. Occlusal adjustments, but not more than once in a 12-month period.

## Type C - Major Covered Services

1. Protective (sedative) fillings.
2. Local chemotherapeutic agents.
3. Initial installation of full or partial Dentures (other than implant supported prosthetics).
4. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 Years prior to replacement.
5. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 Years prior to replacement.
6. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
7. Other removable prosthetic services not described elsewhere.
8. Initial installation of Cast Restorations (except implant supported Cast Restorations).
9. Replacement of any Cast Restoration (except an implant supported Cast Restoration) but only if at least a 5 Year period has passed since the most recent time that:
    - a Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
10. Prefabricated crown, but no more than one replacement for the same tooth surface within 5 Years.
11. Core buildup, but no more than once per tooth in a period of 5 Years.
12. Posts and cores, but no more than once per tooth in a period of 5 Years.
13. Labial veneers, but no more than once per tooth in a period of 5 years.
14. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 60-month period.
15. Repair of implants, but not more than once in a 12-month period.
16. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5-Year period.
17. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5-Year period.
18. Implant supported removable Dentures, but no more than once for the same tooth position in a 5-Year period.
19. Cleaning and inspection of a removable appliance twice in a Year.
20. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards including adjustments and night guards.

## Type D Services – Orthodontic Covered Services

Covered Services include orthodontic work-up including x-rays, diagnostic casts, active treatment plan and retention appliances.

## Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $200, you have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After the Claims Administrator receives this information, the Claims Administrator will provide you with an estimate of the dental benefits available for the service. The estimate is not a guarantee of the amount this Plan will pay. Under the Alternate Benefits provision, benefits may be based on the cost of a service other than the service that you choose. You are required to submit Proof on or after the date the dental service is completed in order for this Plan to pay a benefit for such a service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain this estimate. See “Preservice Determination” section for additional information.

# PPO Dental – Benefit Amounts

## Network Providers

If a Covered Service is provided by a Network Dentist, the maximum amount paid by the Plan is as follows:

- For Type A Covered Services, the Maximum Allowed Charge; or
- For Type B or C Covered Services, the Maximum Allowed Charge times the Covered Percentage specified in the Schedule of Benefits (minus the required Deductible); or
- For Type D Covered Services, the Maximum Allowed Charge times the Covered Percentage specified in the Schedule of Benefits.

As explained under "Alternate Benefits" below, the amount paid by the Plan may be reduced if the Claims Administrator determines that a less costly alternative was available.

In any case in which the Plan pays less than the Maximum Allowed Charge, you or your Dependent are responsible for the balance of the Maximum Allowed Charge.

## Out-of-Network Providers

If a Covered Service is provided by an Out-of-Network Dentist, the maximum amount paid by the Plan is the Reasonable and Customary Charge multiplied by the Covered Percentage specified in the Schedule of Benefits. As explained under "Alternate Benefits" below, the amount paid by the Plan may be reduced if the Claims Administrator determines that a less costly alternative was available.

Out-of-Network Dentists may charge you more than the Reasonable and Customary Charge. You will be responsible for paying:

- the Deductible (Type B and C Covered Services)
- any part of the Reasonable and Customary Charge for which this Plan does not pay benefits; and
- any amount that the Out-of-Network Dentist charges in excess of the Reasonable and Customary Charge.

## Deductibles

The Deductible amounts are shown in the Schedule of Benefits.

The Yearly Individual Deductible is the amount you and each Dependent must pay for Type B or C Covered Services each Year before this Plan will pay benefits for such Covered Services. This Plan applies amounts used to satisfy Yearly individual Deductibles to the Yearly family Deductible. Once the Yearly family Deductible is satisfied, no further Yearly individual Deductibles are required to be met.

When the Claims Administrator determines the amount that the Plan will pay, it first subtracts the deductible; the Plan pays the Covered Percentage of the rest of the amount due. For example, suppose the charge for a Type B service performed by a Network Dentist is $200. Your total cost will be $80. The deductible is $50; the Plan covers $120 (80% of the $150 that remains after your deductible); and you are responsible for the remaining $30.

## Orthodontics

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental benefits are in effect for the person receiving the orthodontic treatment; and

- Proof is given to the Claims Administrator that the orthodontic treatment is continuing.

If the initial placement was made before these dental benefits went into effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits started before these dental benefits went into effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before these dental benefits were in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

## Alternate Benefits

If the Claims Administrator determines that a dental condition could have been treated by performing a service that costs less than the Covered Service the Dentist performed, this Plan will pay benefits based upon the less costly service if the Claims Administrator determines that the less costly service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling, which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling, which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claims Administrator may base the benefit determination upon the partial denture, which is the less costly service.

If this Plan pays benefits based upon a less costly service in accordance with this subsection, the Dentist may charge you or your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by a Network Dentist.

## Multi-Step Services

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this summary plan description, separate steps of one service are considered to be part of the more comprehensive service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Plan will pay benefits only for the root canal therapy.

## Maximum Benefit Amounts

This Plan will pay for Type A, B and C Covered Services received, both Network and Out-of-Network, but will never pay more than the calendar Year maximum. For Type D Covered Services, the Plan will never pay more than the lifetime maximum benefit.

# Copay Dental

| Schedule of Benefits |
| --- |
| **For You and Your Dependents**<br>The Plan includes Network and Out-of-Network Dentists. If you select a PDP or PDP Plus Network Dentist, your cost will generally be less than if you select an Out-of-Network Dentist. |
| **Copayments**<br>The Copayment is the amount that you or your Dependent must pay for a Covered Service provided by a Network Dentist, after which the Plan pays the remainder of the Maximum Allowed Charge. |
| **Deductibles**<br>The Deductible is the amount that you or your Dependent must pay for a Covered Service provided by an Out-of-Network Dentist to which such Deductible applies each Year before this Plan will pay benefits for such service. This Plan applies amounts used to satisfy the Yearly individual Deductible to the Yearly family Deductible. Once the Yearly family Deductible is satisfied, no further Yearly individual Deductibles are required to be met.<br>The amount this Plan applies toward satisfaction of a Deductible for a Covered Service is the amount the Claims Administrator uses to determine benefits for such service. |
| **Network Dentist Payment**<br>A Covered Service provided by a Network Dentist is paid based on the Maximum Allowed Charge that Network Dentists agree to (minus the applicable Copayment).<br>**Out-of-Network Dentist Payment**<br>A Covered Service provided by an Out-of-Network Dentist is paid based on the Maximum Allowed Charge that Network Dentists agree to (minus the applicable Deductible). Members are responsible for 100% of any excess amount billed by Out-of-Network Dentist. |

| COPAY DENTAL BENEFIT HIGHLIGHTS | NETWORK PROVIDER | OUT-OF-NETWORK PROVIDER |
|---|---|---|
| Types A, B and C Combined Calendar Year Maximum | $1,200 | $750 |
| Type D Lifetime Maximum | $1,000 | $1,000 |
| Calendar Year Deductible<br>Individual<br>Family Maximum | <br>None<br>None | <br>$75<br>$225 |
| Type A<br>Preventive/Diagnostic Care | Plan pays an amount equal to the Maximum Allowed Charge less the Copayment for a Covered Service<br>(*see Copayment Schedule on next page*) | 60% of Maximum Allowed Charge (after Deductible) |
| Type B<br>Basic Restorative | Plan pays an amount equal to the Maximum Allowed Charge less the Copayment for a Covered Service<br>(*see Copayment Schedule on next page*) | 40% of Maximum Allowed Charge (after Deductible) |
| Type C<br>Major Restorative | Plan pays an amount equal to the Maximum Allowed Charge less the Copayment for a Covered Service<br>(*see Copayment Schedule on next page*) | 20% of Maximum Allowed Charge<br>(after Deductible) |
| Type D<br>Orthodontic | 50% | 50% of Maximum Allowed Charge |

## Copay Schedule

Copayments in the Copay Dental option vary by service category and geographic location. Geographic locations are divided into four categories based on ZIP code—Area 1 through Area 4. The geographic locations for each area are listed after the copay chart.

| Code | Description | Area 1 | Area 2 | Area 3 | Area 4 |
|---|---|---|---|---|---|
| D0120 | Periodic Oral Evaluation | $ 0 | $ 0 | $ 0 | $ 0 |
| D0140 | Limited Oral Evaluation | $ 5 | $ 5 | $ 5 | $ 5 |
| D0145 | Oral Evaluation Under Age Of 3 | $ 0 | $ 5 | $ 5 | $ 5 |
| D0150 | Comprehensive Oral Evaluation | $ 5 | $ 5 | $ 5 | $ 5 |
| D0160 | Extensive Oral Evaluation | $ 5 | $ 5 | $ 5 | $ 10 |
| D0170 | Limited Oral Re-Evaluation | $ 5 | $ 5 | $ 5 | $ 5 |
| D0180 | Comprehensive Perio Evaluation | $ 5 | $ 5 | $ 5 | $ 5 |
| D0190 | Screening Of A Patient | $ 0 | $ 0 | $ 0 | $ 0 |
| D0191 | Assessment Of A Patient | $ 0 | $ 0 | $ 0 | $ 0 |
| D0210 | Complete Set Radiographic Images | $ 5 | $ 10 | $ 10 | $ 10 |
| D0220 | Periapical Radiographic Image | $ 5 | $ 5 | $ 5 | $ 10 |
| D0230 | Add'l Periapical Images | $ 5 | $ 5 | $ 5 | $ 5 |
| D0240 | Occlusal Radiographic Image | $ 10 | $ 10 | $ 15 | $ 15 |
| D0250 | Extraoral 2d Radiographic Image | $ 20 | $ 20 | $ 25 | $ 25 |
| D0251 | Extraoral Posterior Image | $ 20 | $ 20 | $ 25 | $ 25 |
| D0270 | Bitewing - Single Image | $ 0 | $ 0 | $ 0 | $ 0 |
| D0272 | Bitewings - Two Images | $ 0 | $ 5 | $ 5 | $ 5 |
| D0273 | Bitewings - Three Images | $ 5 | $ 5 | $ 5 | $ 5 |
| D0274 | Bitewings - Four Images | $ 5 | $ 5 | $ 5 | $ 5 |
| D0277 | Vertical Bitewings 7-8 Images | $ 5 | $ 5 | $ 5 | $ 5 |
| D0290 | Skull/Facial Bone Image | $ 25 | $ 25 | $ 30 | $ 35 |
| D0330 | Panoramic Radiographic Image | $ 5 | $ 5 | $ 10 | $ 10 |
| D0340 | 2d Cephalometric Image | $ 25 | $ 30 | $ 35 | $ 35 |
| D0364 | Cone Beam  Less Than Whole Jaw | $ 210 | $ 240 | $ 275 | $ 295 |
| D0365 | Cone Beam Full Arch Mandible | $ 210 | $ 240 | $ 275 | $ 295 |
| D0366 | Cone Beam Full Arch  Maxilla | $ 210 | $ 240 | $ 275 | $ 295 |
| D0367 | Cone Beam Both Jaws | $ 210 | $ 240 | $ 275 | $ 295 |
| D0368 | Cone Beam - Tmj | $ 210 | $ 240 | $ 275 | $ 295 |
| D0380 | Cone Beam Capt Less Than One Jaw | $ 210 | $ 240 | $ 275 | $ 295 |
| D0381 | Cone Beam Capture - Mandible | $ 210 | $ 240 | $ 275 | $ 295 |
| D0382 | Cone Beam Capture - Maxilla | $ 210 | $ 240 | $ 275 | $ 295 |
| D0383 | Cone Beam Capture - Both Jaws | $ 210 | $ 240 | $ 275 | $ 295 |
| D0384 | Cone Beam Capture - Tmj Series | $ 210 | $ 240 | $ 275 | $ 295 |
| D0391 | Interpretation-Diagnostic Image | $ 10 | $ 15 | $ 15 | $ 15 |
| D0415 | Lab Test | $ 15 | $ 15 | $ 20 | $ 25 |
| D0417 | Saliva Sample Collection | $ 10 | $ 15 | $ 15 | $ 20 |
| D0460 | Pulp Vitality Test | $ 10 | $ 15 | $ 15 | $ 15 |
| D0470 | Diagnostic Casts | $ 25 | $ 30 | $ 30 | $ 35 |

| | | | | | |
|---|---|---|---|---|---|
| D1110 | Cleaning - Adult | $ 10 | $ 10 | $ 10 | $ 10 |
| D1120 | Cleaning - Child | $ 10 | $ 10 | $ 10 | $ 10 |
| D1206 | Topical Fluoride-Varnish | $ 5 | $ 5 | $ 5 | $ 5 |
| D1208 | Topical Application-Fluoride | $ 0 | $ 5 | $ 5 | $ 5 |
| D1351 | Sealant - Per Tooth | $ 10 | $ 10 | $ 15 | $ 15 |
| D1352 | Preventive Resin Restoration | $ 10 | $ 15 | $ 15 | $ 15 |
| D1353 | Sealant Repair-Per Tooth | $ 0 | $ 0 | $ 0 | $ 0 |
| D1354 | Interim Caries Medicament | $ 5 | $ 5 | $ 5 | $ 10 |
| D1510 | Space Maintainer Fixed-Unilateral | $ 95 | $ 105 | $ 120 | $ 130 |
| D1515 | Space Maintainer Fixed-Bilateral | $ 130 | $ 145 | $ 165 | $ 180 |
| D1520 | Space Maintainer Rem-Unilateral | $ 95 | $ 105 | $ 120 | $ 130 |
| D1525 | Space Maintainer Rem-Bilateral | $ 165 | $ 185 | $ 210 | $ 225 |
| D1550 | Recement Space Maintainer | $ 15 | $ 15 | $ 20 | $ 20 |
| D2140 | One Surface Amalgam | $ 25 | $ 30 | $ 35 | $ 45 |
| D2150 | Two Surface Amalgam | $ 35 | $ 40 | $ 45 | $ 55 |
| D2160 | Three Surface Amalgam | $ 40 | $ 50 | $ 55 | $ 65 |
| D2161 | Four Or More Surface Amalgam | $ 50 | $ 55 | $ 65 | $ 80 |
| D2330 | One Surface Composite Anterior | $ 30 | $ 35 | $ 40 | $ 50 |
| D2331 | Two Surface Composite Anterior | $ 40 | $ 45 | $ 50 | $ 60 |
| D2332 | Three Surface Composite Anterior | $ 45 | $ 55 | $ 60 | $ 75 |
| D2335 | 4 Or More Surf Composite Ant | $ 55 | $ 65 | $ 75 | $ 90 |
| D2390 | Resin Crown | $ 100 | $ 115 | $ 130 | $ 160 |
| D2391 | One Surface Composite Posterior | $ 35 | $ 40 | $ 45 | $ 50 |
| D2392 | Two Surface Composite Posterior | $ 45 | $ 50 | $ 55 | $ 70 |
| D2393 | 3 Surface Composite Posterior | $ 55 | $ 60 | $ 70 | $ 85 |
| D2394 | 4 Or More Surf Composite Post | $ 55 | $ 65 | $ 75 | $ 95 |
| D2410 | 1 Surface Gold Foil | $ 120 | $ 135 | $ 155 | $ 170 |
| D2420 | 2 Surface Gold Foil | $ 170 | $ 195 | $ 220 | $ 235 |
| D2430 | 3 Surface Gold Foil | $ 205 | $ 230 | $ 265 | $ 280 |
| D2510 | One Surface Metallic Inlay | $ 250 | $ 285 | $ 325 | $ 370 |
| D2520 | Two Surface Metallic Inlay | $ 310 | $ 350 | $ 395 | $ 450 |
| D2530 | Three Surface Metallic Inlay | $ 335 | $ 375 | $ 425 | $ 470 |
| D2542 | Two Surface Metallic Onlay | $ 380 | $ 430 | $ 490 | $ 550 |
| D2543 | Three Surface Metallic Onlay | $ 390 | $ 445 | $ 505 | $ 555 |
| D2544 | 4 Or More Surf. Metallic Onlay | $ 405 | $ 465 | $ 525 | $ 595 |
| D2610 | One Surface Porcelain Inlay | $ 300 | $ 335 | $ 375 | $ 435 |
| D2620 | 2 Surface Porcelain Inlay | $ 330 | $ 370 | $ 420 | $ 465 |
| D2630 | 3 Or More Surf. Porcelain Inlay | $ 385 | $ 435 | $ 495 | $ 535 |
| D2642 | 2 Surfaces - Porcelain Onlay | $ 440 | $ 505 | $ 575 | $ 625 |
| D2643 | 3 Surfaces - Porcelain Onlay | $ 455 | $ 520 | $ 590 | $ 640 |
| D2644 | 4 Or More Surf. Porcelain Onlay | $ 465 | $ 530 | $ 600 | $ 650 |
| D2650 | 1 Surface Composite/Resin Inlay | $ 230 | $ 255 | $ 285 | $ 300 |
| D2651 | 2 Surface Composite/Resin Inlay | $ 265 | $ 300 | $ 335 | $ 380 |

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|---|---|---|---|---|---|
| D2652 | 3 Or More Surf Comp/Resin Inlay | $ 295 | $ 335 | $ 375 | $ 400 |
| D2662 | 2 Surface Composite/Resin Onlay | $ 365 | $ 410 | $ 470 | $ 520 |
| D2663 | 3 Surface Composite/Resin Onlay | $ 365 | $ 415 | $ 465 | $ 515 |
| D2664 | 4 Or More Surf Comp/Resin Onlay | $ 375 | $ 425 | $ 480 | $ 535 |
| D2710 | Resin Crown (Indirect) | $ 170 | $ 195 | $ 215 | $ 235 |
| D2712 | Crown 3/4 Resin Based Indirect | $ 160 | $ 185 | $ 205 | $ 230 |
| D2720 | Crown Resin W/High Noble Metal | $ 415 | $ 470 | $ 535 | $ 590 |
| D2721 | Crown Resin W/Base Metal | $ 325 | $ 365 | $ 415 | $ 440 |
| D2722 | Crown Resin W/Noble Metal | $ 360 | $ 410 | $ 465 | $ 505 |
| D2740 | Crown Porcelain/Ceramic | $ 435 | $ 500 | $ 565 | $ 630 |
| D2750 | Crown Porcelain-High Noble Metal | $ 435 | $ 495 | $ 565 | $ 620 |
| D2751 | Crown Porcelain-Base Metal | $ 395 | $ 450 | $ 510 | $ 555 |
| D2752 | Crown Porcelain-Noble Metal | $ 410 | $ 470 | $ 530 | $ 580 |
| D2780 | Crown 3/4 High Noble | $ 425 | $ 485 | $ 555 | $ 610 |
| D2781 | Crown 3/4 Base Metal | $ 395 | $ 445 | $ 500 | $ 565 |
| D2782 | Crown 3/4 Cast Noble Metal | $ 395 | $ 450 | $ 510 | $ 555 |
| D2783 | Crown 3/4 Porcelain/Ceramic | $ 435 | $ 500 | $ 570 | $ 615 |
| D2790 | Crown High Noble | $ 400 | $ 460 | $ 525 | $ 595 |
| D2791 | Crown Full Cast/Base Metal | $ 360 | $ 410 | $ 465 | $ 520 |
| D2792 | Crown Full Cast Noble Metal | $ 370 | $ 425 | $ 480 | $ 550 |
| D2794 | Titanium Crown | $ 390 | $ 445 | $ 505 | $ 545 |
| D2910 | Recement Inlay, Onlay | $ 30 | $ 35 | $ 35 | $ 50 |
| D2915 | Recement Cast - Post Core | $ 30 | $ 30 | $ 35 | $ 45 |
| D2920 | Recement Crown | $ 30 | $ 35 | $ 40 | $ 50 |
| D2929 | Prefab Por/Cer Crown-Primary | $ 60 | $ 65 | $ 75 | $ 90 |
| D2930 | Stainless Steel Crown - Child | $ 85 | $ 95 | $ 110 | $ 130 |
| D2931 | Stainless Steel Crown - Adult | $ 90 | $ 100 | $ 115 | $ 150 |
| D2932 | Resin Crown | $ 95 | $ 105 | $ 120 | $ 140 |
| D2933 | Stainless Steel Crown/Resin | $ 115 | $ 130 | $ 150 | $ 165 |
| D2934 | Ss Crown Primary Tooth | $ 85 | $ 100 | $ 115 | $ 130 |
| D2940 | Sedative Filling | $ 15 | $ 20 | $ 20 | $ 30 |
| D2950 | Core Buildup | $ 70 | $ 85 | $ 95 | $ 125 |
| D2951 | Pin Retention Per Tooth | $ 10 | $ 15 | $ 15 | $ 20 |
| D2952 | Post And Core | $ 150 | $ 175 | $ 195 | $ 210 |
| D2953 | Cast Post - Each Addl Same Tooth | $ 20 | $ 20 | $ 25 | $ 30 |
| D2954 | Prefab Post And Core | $ 105 | $ 120 | $ 135 | $ 160 |
| D2957 | Steel Post - Each Addl Same Tooth | $ 10 | $ 15 | $ 15 | $ 25 |
| D2960 | Resin Labial Veneer-Chairside | $ 180 | $ 205 | $ 230 | $ 275 |
| D2961 | Resin Labial Veneer-Laboratory | $ 290 | $ 320 | $ 365 | $ 405 |
| D2962 | Porcelain Labial Veneer | $ 365 | $ 415 | $ 465 | $ 545 |
| D2971 | Addl Crown Procedure | $ 70 | $ 80 | $ 90 | $ 105 |
| D2980 | Crown Repair | $ 75 | $ 85 | $ 95 | $ 115 |
| D2981 | Inlay Repair | $ 75 | $ 85 | $ 95 | $ 115 |

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|---|---|---|---|---|---|
| D2982 | Onlay Repair | $ 75 | $ 85 | $ 95 | $ 115 |
| D2983 | Veneer Repair | $ 75 | $ 80 | $ 90 | $ 115 |
| D2990 | Resin Infiltration/Smooth Surf | $ 10 | $ 15 | $ 15 | $ 15 |
| D3110 | Pulp Cap-Direct | $ 15 | $ 15 | $ 20 | $ 20 |
| D3120 | Pulp Cap-Indirect | $ 15 | $ 15 | $ 20 | $ 20 |
| D3220 | Therapeutic Pulpotomy | $ 30 | $ 35 | $ 40 | $ 50 |
| D3221 | Pulpal Debridement | $ 20 | $ 20 | $ 25 | $ 45 |
| D3222 | Partial Pulpotomy - Apexogenesis | $ 30 | $ 35 | $ 40 | $ 50 |
| D3230 | Pulpal Therapy Ant/Primary Tooth | $ 105 | $ 120 | $ 140 | $ 145 |
| D3240 | Pulpal Therapy Post/Primary Th | $ 130 | $ 150 | $ 170 | $ 175 |
| D3310 | Endodontic Therapy - Anterior | $ 265 | $ 295 | $ 340 | $ 390 |
| D3320 | Endodontic Therapy - Bicuspid | $ 310 | $ 350 | $ 400 | $ 460 |
| D3330 | Endodontic Therapy - Molar | $ 420 | $ 470 | $ 535 | $ 580 |
| D3331 | Treatment Of Root Canal Obstruct | $ 80 | $ 90 | $ 105 | $ 110 |
| D3332 | Incomplete Root Canal Therapy | $ 120 | $ 135 | $ 155 | $ 190 |
| D3333 | Root Perforation Repair | $ 70 | $ 75 | $ 85 | $ 100 |
| D3346 | Root Canal Retreat/Anterior | $ 325 | $ 365 | $ 415 | $ 475 |
| D3347 | Root Canal Retreat/Bicuspid | $ 365 | $ 415 | $ 475 | $ 540 |
| D3348 | Root Canal Retreatment - Molar | $ 475 | $ 535 | $ 615 | $ 675 |
| D3351 | Apexification - Initial Visit | $ 110 | $ 125 | $ 140 | $ 165 |
| D3352 | Apexification/Recalcification | $ 65 | $ 70 | $ 80 | $ 90 |
| D3353 | Apexification - Final Visit | $ 165 | $ 185 | $ 210 | $ 255 |
| D3355 | Pulpal Regeneration - Initial Visit | $ 65 | $ 70 | $ 80 | $ 90 |
| D3356 | Pulpal Regeneration - Interim Medication Replacement | $ 30 | $ 35 | $ 40 | $ 45 |
| D3357 | Pulpal Regeneration - Completion Of Treatment | $ 65 | $ 70 | $ 80 | $ 90 |
| D3410 | Apicoectomy - Anterior | $ 245 | $ 270 | $ 310 | $ 365 |
| D3421 | Apicoectomy - Bicuspid | $ 280 | $ 310 | $ 355 | $ 410 |
| D3425 | Apicoectomy - Molar | $ 310 | $ 350 | $ 400 | $ 450 |
| D3426 | Apicoectomy - Additional Root | $ 120 | $ 135 | $ 150 | $ 175 |
| D3427 | Periradicular Surgery Without Apioectomy | $ 230 | $ 260 | $ 295 | $ 340 |
| D3428 | Bone Graft In Conjunction With Periradicular Surgery | $ 170 | $ 190 | $ 205 | $ 235 |
| D3429 | Bone Graft In Conjunction With Periradicular Surgery | $ 110 | $ 125 | $ 140 | $ 125 |
| D3430 | Retrograde Filling - Per Root | $ 75 | $ 85 | $ 95 | $ 120 |
| D3431 | Biologic Materials To Aid In Soft And Osseous Tissue Regeneration | $ 105 | $ 120 | $ 135 | $ 175 |
| D3432 | Guided Tissue Regeneration, Resorbable Barrier | $ 160 | $ 185 | $ 205 | $ 260 |
| D3450 | Root Amputation - Per Root | $ 180 | $ 200 | $ 225 | $ 250 |
| D3920 | Hemisection | $ 150 | $ 165 | $ 190 | $ 205 |
| D4210 | Gingivectomy/Plasty Full Quad | $ 200 | $ 230 | $ 260 | $ 280 |
| D4211 | Gingivectomy/Plasty - 1-3 Teeth | $ 35 | $ 40 | $ 50 | $ 60 |
| D4212 | Gingivectomy/Plasty W/Rest-Tooth | $ 35 | $ 40 | $ 40 | $ 45 |
| D4240 | Gingival Flap Proc Full Quad | $ 220 | $ 245 | $ 280 | $ 310 |
| D4241 | Gingival Flap 1 - 3 Teeth | $ 140 | $ 155 | $ 175 | $ 195 |

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|---|---|---|---|---|---|
| D4245 | Apically Positioned Flap | $ 120 | $ 130 | $ 150 | $ 170 |
| D4249 | Crown Lengthening | $ 320 | $ 365 | $ 415 | $ 435 |
| D4260 | Osseous Surgery - 4 Or More Teeth | $ 445 | $ 505 | $ 575 | $ 630 |
| D4261 | Osseous Surgery 1 - 3 Teeth | $ 280 | $ 320 | $ 365 | $ 410 |
| D4263 | Bone Graft - First Site | $ 170 | $ 190 | $ 210 | $ 235 |
| D4264 | Bone Graft - Additional Site | $ 110 | $ 125 | $ 140 | $ 125 |
| D4265 | Biologic Materials | $ 110 | $ 125 | $ 140 | $ 175 |
| D4266 | Gtr - Resorbable Barrier | $ 160 | $ 185 | $ 210 | $ 260 |
| D4267 | Gtr - Nonresorbable Barrier | $ 200 | $ 225 | $ 255 | $ 305 |
| D4268 | Surgical Revision Procedure | $ 55 | $ 60 | $ 70 | $ 90 |
| D4270 | Pedicle Soft Tissue Graft | $ 250 | $ 275 | $ 310 | $ 385 |
| D4273 | Autogenous Tissue Graft | $ 390 | $ 445 | $ 505 | $ 575 |
| D4274 | Distal/Proximl Wedge | $ 140 | $ 155 | $ 175 | $ 225 |
| D4275 | Non Autogenous Tissue Graft | $ 370 | $ 425 | $ 480 | $ 525 |
| D4276 | Combined Tissue Grafting/Tooth | $ 400 | $ 455 | $ 510 | $ 585 |
| D4277 | Free Soft Tissue Graft 1st Tooth | $ 320 | $ 360 | $ 415 | $ 470 |
| D4278 | Free Soft Tissue Graft-Addl Tooth | $ 165 | $ 185 | $ 210 | $ 235 |
| D4283 | Subepithelial Tissue Graft/Addl | $ 195 | $ 225 | $ 255 | $ 290 |
| D4285 | Soft Tissue Allograft Additional | $ 185 | $ 210 | $ 240 | $ 265 |
| D4341 | Scaling/Root Planing - Per Quad | $ 80 | $ 90 | $ 105 | $ 120 |
| D4342 | Scaling & Root Planing 1-3 Teeth | $ 50 | $ 60 | $ 65 | $ 75 |
| D4355 | Full Mouth Debridement | $ 40 | $ 45 | $ 55 | $ 70 |
| D4381 | Delivery Of Antimicrobial Agents | $ 35 | $ 40 | $ 45 | $ 55 |
| D4910 | Periodontal Maintenance | $ 30 | $ 35 | $ 40 | $ 45 |
| D4920 | Dressing Change | $ 20 | $ 25 | $ 30 | $ 30 |
| D5110 | Complete Upper Denture | $ 535 | $ 605 | $ 685 | $ 765 |
| D5120 | Complete Lower Denture | $ 535 | $ 605 | $ 685 | $ 765 |
| D5130 | Immediate Denture Maxillary | $ 570 | $ 650 | $ 740 | $ 855 |
| D5140 | Immediate Denture Mandibular | $ 570 | $ 650 | $ 740 | $ 855 |
| D5211 | Upper Partial Denture - Resin | $ 395 | $ 450 | $ 510 | $ 570 |
| D5212 | Lower Partial Denture - Resin | $ 395 | $ 450 | $ 510 | $ 570 |
| D5213 | Upper Partial Denture - Cast | $ 650 | $ 725 | $ 820 | $ 885 |
| D5214 | Lower Partial Denture - Cast | $ 650 | $ 725 | $ 820 | $ 885 |
| D5221 | Immediate Max Partial Resin | $ 395 | $ 450 | $ 510 | $ 570 |
| D5222 | Immediate Mand Partial Resin | $ 395 | $ 450 | $ 510 | $ 570 |
| D5223 | Immediate Max Partial Metal | $ 650 | $ 725 | $ 820 | $ 885 |
| D5224 | Immediate Mand Partial Metal | $ 650 | $ 725 | $ 820 | $ 885 |
| D5225 | Upper Partial Denture - Flexible | $ 475 | $ 540 | $ 605 | $ 675 |
| D5226 | Lower Partial Denture - Flexible | $ 475 | $ 540 | $ 605 | $ 675 |
| D5281 | Unilateral Partial Denture | $ 245 | $ 275 | $ 315 | $ 405 |
| D5410 | Adjust Upper Complete Denture | $ 25 | $ 30 | $ 30 | $ 40 |
| D5411 | Adjust Lower Complete Denture | $ 25 | $ 30 | $ 30 | $ 40 |
| D5421 | Adjust Upper Partial Denture | $ 25 | $ 30 | $ 30 | $ 40 |

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|---|---|---|---|---|---|
| D5422 | Adjust Lower Partial Denture | $ 25 | $ 30 | $ 30 | $ 40 |
| D5510 | Repair Denture Base | $ 75 | $ 85 | $ 100 | $ 105 |
| D5520 | Replace Th On Denture-Per Th | $ 65 | $ 75 | $ 85 | $ 95 |
| D5610 | Repair Resin Denture Base | $ 55 | $ 65 | $ 75 | $ 85 |
| D5620 | Repair Denture / Cast Framework | $ 65 | $ 75 | $ 85 | $ 105 |
| D5630 | Repair/Replace Broken Clasp | $ 65 | $ 70 | $ 80 | $ 100 |
| D5640 | Replace Tooth On Denture | $ 65 | $ 75 | $ 85 | $ 95 |
| D5650 | Add Tooth To Denture | $ 70 | $ 80 | $ 90 | $ 105 |
| D5660 | Add Clasp Partial Denture | $ 90 | $ 100 | $ 115 | $ 125 |
| D5670 | Replace Max Teeth & Framework | $ 175 | $ 195 | $ 225 | $ 245 |
| D5671 | Replace Mand. Teeth & Framework | $ 175 | $ 200 | $ 230 | $ 250 |
| D5710 | Rebase Complete Upper Denture | $ 195 | $ 225 | $ 255 | $ 285 |
| D5711 | Rebase Complete Lower Denture | $ 190 | $ 220 | $ 250 | $ 275 |
| D5720 | Rebase Upper Partial Denture | $ 175 | $ 195 | $ 225 | $ 250 |
| D5721 | Rebase Lower Partial Denture | $ 175 | $ 195 | $ 225 | $ 250 |
| D5730 | Reline Upper Denture - Chairside | $ 110 | $ 125 | $ 145 | $ 160 |
| D5731 | Reline Lower Denture - Chairside | $ 110 | $ 125 | $ 145 | $ 165 |
| D5740 | Reline Upper Denture - Chairside | $ 90 | $ 105 | $ 115 | $ 150 |
| D5741 | Reline Lower Denture - Chairside | $ 90 | $ 105 | $ 115 | $ 150 |
| D5750 | Reline Upper Denture - Lab | $ 165 | $ 185 | $ 215 | $ 230 |
| D5751 | Reline Lower Denture - Lab | $ 165 | $ 185 | $ 215 | $ 235 |
| D5760 | Reline Upper Denture - Lab | $ 145 | $ 165 | $ 190 | $ 210 |
| D5761 | Reline Lower Denture - Lab | $ 145 | $ 165 | $ 185 | $ 215 |
| D5850 | Tissue Conditioning - Upper | $ 55 | $ 60 | $ 70 | $ 80 |
| D5851 | Tissue Conditioning - Lower | $ 55 | $ 60 | $ 70 | $ 75 |
| D5863 | Overdenture - Complete Maxillary | $ 700 | $ 785 | $ 890 | $ 965 |
| D5864 | Overdenture - Partial Maxillary | $ 630 | $ 715 | $ 810 | $ 895 |
| D5865 | Overdenture - Complete Mandibular | $ 700 | $ 785 | $ 890 | $ 970 |
| D5866 | Overdenture - Partial Mandibular | $ 630 | $ 715 | $ 810 | $ 895 |
| D6010 | Endosteal Implant | $ 825 | $ 940 | $ 999 | $ 999 |
| D6012 | Placement Of Interim Implant | $ 0 | $ 0 | $ 0 | $ 0 |
| D6013 | Surgical Placement Of Mini Implant | $ 820 | $ 930 | $ 999 | $ 999 |
| D6040 | Eposteal Implant | $ 999 | $ 999 | $ 999 | $ 999 |
| D6050 | Transosteal Implant | $ 999 | $ 999 | $ 999 | $ 999 |
| D6051 | Interim Abutment | $ 140 | $ 160 | $ 180 | $ 170 |
| D6052 | Semi-Precision Attachment Abutment | $ 370 | $ 415 | $ 470 | $ 460 |
| D6055 | Implant Connecting Bar | $ 365 | $ 410 | $ 465 | $ 520 |
| D6056 | Prefab Implant Abutment | $ 285 | $ 320 | $ 365 | $ 350 |
| D6057 | Custom Implant Abutment | $ 375 | $ 420 | $ 475 | $ 460 |
| D6058 | Implant Crown - Porcelain | $ 545 | $ 620 | $ 700 | $ 725 |
| D6059 | Implant Crown- Porcel-High Noble | $ 515 | $ 585 | $ 665 | $ 710 |
| D6060 | Implant Crown- Porcel Base Metal | $ 465 | $ 530 | $ 600 | $ 635 |
| D6061 | Implant Crown-Porcel Noble Metal | $ 495 | $ 565 | $ 645 | $ 655 |

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|---|---|---|---|---|---|
| D6062 | Implant Crown - Cast High Noble | $ 495 | $ 560 | $ 640 | $ 700 |
| D6063 | Implant Crown - Cast Base Metal | $ 430 | $ 490 | $ 550 | $ 570 |
| D6064 | Implant Crown - Cast Noble Metal | $ 460 | $ 525 | $ 595 | $ 615 |
| D6065 | Implant Crown - Porcelain | $ 530 | $ 605 | $ 685 | $ 750 |
| D6066 | Implant Crown - Porcelain-Metal | $ 515 | $ 585 | $ 665 | $ 720 |
| D6067 | Implant Crown - Metal | $ 500 | $ 565 | $ 645 | $ 695 |
| D6068 | Implant Retainer - Porcelain | $ 530 | $ 600 | $ 680 | $ 685 |
| D6069 | Implant Retainer - Porcel-Metal | $ 505 | $ 575 | $ 650 | $ 675 |
| D6070 | Implant Retainer - Base Metal | $ 465 | $ 525 | $ 595 | $ 600 |
| D6071 | Implant Retainer - Noble Metal | $ 490 | $ 555 | $ 635 | $ 635 |
| D6072 | Implant Retainer - High Noble | $ 485 | $ 545 | $ 625 | $ 635 |
| D6073 | Implant Retainer - Base Metal | $ 400 | $ 450 | $ 515 | $ 530 |
| D6074 | Implant Retainer - Noble Metal | $ 440 | $ 500 | $ 565 | $ 595 |
| D6075 | Implant Retainer - Ceramic | $ 505 | $ 575 | $ 650 | $ 650 |
| D6076 | Implant Retainer - High Noble | $ 505 | $ 570 | $ 650 | $ 690 |
| D6077 | Implant Retainer-Cast-High Noble | $ 470 | $ 535 | $ 605 | $ 635 |
| D6080 | Implant Maintenance Procedures | $ 40 | $ 45 | $ 55 | $ 65 |
| D6090 | Repair Implant Prosthesis | $ 95 | $ 110 | $ 125 | $ 140 |
| D6091 | Precision Attachment Replacement | $ 165 | $ 190 | $ 215 | $ 240 |
| D6092 | Recement Implant Crown | $ 30 | $ 35 | $ 35 | $ 50 |
| D6093 | Recement Implant Fixed Denture | $ 45 | $ 55 | $ 60 | $ 70 |
| D6094 | Implant Crown - Titanium | $ 470 | $ 530 | $ 605 | $ 615 |
| D6095 | Repair Implant Abutment,Report | $ 110 | $ 125 | $ 145 | $ 155 |
| D6100 | Implant Removal, By Report | $ 140 | $ 155 | $ 180 | $ 270 |
| D6101 | Debridement Periimplant Defect | $ 40 | $ 45 | $ 50 | $ 60 |
| D6102 | Debride/Oss Periimplant Defect | $ 85 | $ 95 | $ 110 | $ 115 |
| D6103 | Bone Graft/Periimplant Defect | $ 180 | $ 210 | $ 240 | $ 305 |
| D6104 | Bone Graft Implant Placement | $ 180 | $ 210 | $ 240 | $ 310 |
| D6110 | Implant Overdenture-Maxillary | $ 999 | $ 999 | $ 999 | $ 999 |
| D6111 | Implant Overdenture-Mandibular | $ 999 | $ 999 | $ 999 | $ 999 |
| D6112 | Implant Overdenture Partial-Max | $ 955 | $ 999 | $ 999 | $ 999 |
| D6113 | Implant Overdenture Partial-Mand | $ 955 | $ 999 | $ 999 | $ 999 |
| D6114 | Implant Supp Fixed Denture Max | $ 999 | $ 999 | $ 999 | $ 999 |
| D6115 | Implant Supp Fixed Denturemand | $ 999 | $ 999 | $ 999 | $ 999 |
| D6116 | Implant Supp Fixed Partial Max | $ 999 | $ 999 | $ 999 | $ 999 |
| D6117 | Implant Supp Fixed Partial Mand | $ 999 | $ 999 | $ 999 | $ 999 |
| D6190 | Implant Index | $ 100 | $ 110 | $ 125 | $ 130 |
| D6194 | Implant Retainer - Titanium | $ 450 | $ 510 | $ 580 | $ 590 |
| D6205 | Pontic - Indirect Composite | $ 300 | $ 340 | $ 385 | $ 425 |
| D6210 | Pontic - Cast High Noble | $ 390 | $ 445 | $ 510 | $ 570 |
| D6211 | Pontic - Cast Base Metal | $ 350 | $ 400 | $ 455 | $ 510 |
| D6212 | Pontic - Cast Noble Metal | $ 365 | $ 415 | $ 475 | $ 535 |
| D6214 | Pontic - Titanium | $ 370 | $ 420 | $ 475 | $ 530 |

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| D6240 | Pontic - Porcelain - High Noble | $ 410 | $ 465 | $ 530 | $ 585 |
| D6241 | Pontic - Porcelain - Base Metal | $ 380 | $ 435 | $ 495 | $ 525 |
| D6242 | Pontic - Porcelain Noble Metal | $ 400 | $ 455 | $ 515 | $ 555 |
| D6245 | Pontic - Porcelain | $ 430 | $ 490 | $ 560 | $ 620 |
| D6250 | Pontic-Resin W/High Noble Metal | $ 415 | $ 470 | $ 535 | $ 585 |
| D6251 | Pontic - Resin W/Base Metal | $ 315 | $ 350 | $ 400 | $ 440 |
| D6252 | Pontic - Resin W/Noble Metal | $ 340 | $ 385 | $ 435 | $ 480 |
| D6545 | Cast Metal Retainer | $ 170 | $ 190 | $ 220 | $ 250 |
| D6548 | Retainer - Porcelain/Ceramic | $ 190 | $ 215 | $ 250 | $ 365 |
| D6549 | Resin Retainer-Fixed Prosthesis | $ 140 | $ 160 | $ 190 | $ 275 |
| D6600 | Retainer Inlay Ceramic 2 Surface | $ 390 | $ 440 | $ 500 | $ 535 |
| D6601 | Retainer Inlay Ceramic 3 Or More | $ 400 | $ 450 | $ 515 | $ 550 |
| D6602 | Retainer Inlay High Noble 2 Surf | $ 290 | $ 325 | $ 370 | $ 405 |
| D6603 | Retainer Inlay High Noble 3-More | $ 315 | $ 355 | $ 405 | $ 450 |
| D6604 | Retainer Inlay Metal 2 Surf | $ 280 | $ 315 | $ 360 | $ 385 |
| D6605 | Retainer Inlay Metal 3-More | $ 295 | $ 335 | $ 380 | $ 415 |
| D6606 | Retainer Inlay Cast Metal 2 Surf | $ 280 | $ 315 | $ 360 | $ 395 |
| D6607 | Retainer Inlay Cast Metal 3-More | $ 315 | $ 355 | $ 405 | $ 430 |
| D6608 | Retainer Onlay Ceramic 2 Surf | $ 395 | $ 450 | $ 515 | $ 545 |
| D6609 | Retainer Onlay Ceramic 3 Or More | $ 410 | $ 465 | $ 530 | $ 560 |
| D6610 | Retainer Onlay High Noble 2 Surf | $ 335 | $ 375 | $ 425 | $ 450 |
| D6611 | Retainer Onlay High Noble 3 Or More | $ 375 | $ 425 | $ 485 | $ 525 |
| D6612 | Retainer Onlay Base Metal 2 Surf | $ 320 | $ 355 | $ 405 | $ 425 |
| D6613 | Retainer Onlay Base Metal 3 Or More | $ 365 | $ 410 | $ 470 | $ 510 |
| D6614 | Retainer Onlay Cast Noble 2 Surf | $ 325 | $ 360 | $ 410 | $ 435 |
| D6615 | Retainer Onlay Cast Noble 3 Or More | $ 370 | $ 420 | $ 475 | $ 510 |
| D6624 | Retainer Inlay - Titanium | $ 270 | $ 305 | $ 345 | $ 375 |
| D6634 | Retainer Onlay - Titanium | $ 320 | $ 360 | $ 405 | $ 430 |
| D6710 | Retainer Crown Indirect Resin | $ 305 | $ 345 | $ 390 | $ 410 |
| D6720 | Retainer Crown-Resin High Noble | $ 415 | $ 470 | $ 535 | $ 585 |
| D6721 | Retainer Crown-Resin Base Metal | $ 330 | $ 370 | $ 415 | $ 440 |
| D6722 | Retainer Crown-Resin Noble Metal | $ 355 | $ 400 | $ 455 | $ 495 |
| D6740 | Retainer Crown-Porcelain/Ceramic | $ 445 | $ 510 | $ 580 | $ 645 |
| D6750 | Retainer Crown-Porc-High Noble | $ 435 | $ 495 | $ 565 | $ 620 |
| D6751 | Retainer Crown-Porc-Base Metal | $ 395 | $ 450 | $ 510 | $ 555 |
| D6752 | Retainer Crown-Porc-Noble Metal | $ 410 | $ 470 | $ 530 | $ 580 |
| D6780 | Retainer Crown 3/4 Cast High Noble | $ 410 | $ 470 | $ 530 | $ 590 |
| D6781 | Retainer Crown 3/4 Base Metal | $ 365 | $ 410 | $ 465 | $ 505 |
| D6782 | Retainer Crown-3/4 Noble Metal | $ 375 | $ 430 | $ 490 | $ 535 |
| D6783 | Retainer Crown-3/4 Porcelain | $ 430 | $ 490 | $ 555 | $ 600 |
| D6790 | Retainer Crown Full Cast High | $ 400 | $ 460 | $ 520 | $ 580 |
| D6791 | Retainer Crown-Full Cast Base | $ 355 | $ 405 | $ 460 | $ 515 |
| D6792 | Retainer Crown-Full Cast Noble | $ 375 | $ 425 | $ 485 | $ 555 |

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| D6794 | Retainer Crown - Titanium | $ 385 | $ 435 | $ 495 | $ 545 |
| D6920 | Connector Bar | $ 270 | $ 305 | $ 345 | $ 375 |
| D6930 | Recement Bridge | $ 45 | $ 50 | $ 60 | $ 75 |
| D6980 | Bridge Repair, By Report | $ 70 | $ 80 | $ 90 | $ 115 |
| D7111 | Extract Coronal Remnants | $ 45 | $ 50 | $ 55 | $ 65 |
| D7140 | Extract Erupt Tooth/Exposed Root | $ 50 | $ 55 | $ 60 | $ 80 |
| D7210 | Extract Erupted Tooth - Surgical | $ 85 | $ 95 | $ 110 | $ 135 |
| D7220 | Extract Impacted Tooth Soft Tiss | $ 110 | $ 125 | $ 140 | $ 165 |
| D7230 | Extract Impacted Tooth Part Bony | $ 135 | $ 155 | $ 175 | $ 200 |
| D7240 | Extract Impacted Tooth Comp Bony | $ 170 | $ 195 | $ 225 | $ 240 |
| D7241 | Ext Impacted Tooth Bony W/Compl | $ 195 | $ 220 | $ 255 | $ 270 |
| D7250 | Remove Residual Root | $ 90 | $ 105 | $ 115 | $ 145 |
| D7251 | Coronectomy | $ 170 | $ 195 | $ 225 | $ 240 |
| D7260 | Oroantral Fistula Surgery | $ 290 | $ 330 | $ 370 | $ 400 |
| D7261 | Prim. Sinus Perforation Closure | $ 305 | $ 345 | $ 390 | $ 415 |
| D7270 | Tooth Replantation | $ 155 | $ 175 | $ 200 | $ 245 |
| D7272 | Tooth Transplantation | $ 150 | $ 170 | $ 195 | $ 215 |
| D7280 | Unerupted Tooth Access | $ 170 | $ 195 | $ 225 | $ 265 |
| D7282 | Mobilize To Aid Eruption | $ 150 | $ 170 | $ 195 | $ 225 |
| D7287 | Cytology Sample | $ 30 | $ 35 | $ 40 | $ 60 |
| D7288 | Brush Biopsy | $ 35 | $ 40 | $ 45 | $ 65 |
| D7290 | Reposition Teeth - Surgical | $ 160 | $ 185 | $ 210 | $ 235 |
| D7310 | Alveoplasty - With Extractions | $ 80 | $ 90 | $ 105 | $ 120 |
| D7311 | Alveoplasty W Extractions | $ 50 | $ 55 | $ 65 | $ 70 |
| D7320 | Alveoplasty W/O Extraction | $ 125 | $ 140 | $ 155 | $ 200 |
| D7321 | Alveoplasty W/O Extraction | $ 75 | $ 85 | $ 95 | $ 120 |
| D7340 | Vestibuloplasty | $ 405 | $ 455 | $ 515 | $ 550 |
| D7350 | Vestibuloplasty | $ 999 | $ 999 | $ 999 | $ 999 |
| D7450 | Remove Odontogenic Cyst/Tumor | $ 155 | $ 175 | $ 200 | $ 240 |
| D7451 | Remove Odontogenic Cyst/Tumor | $ 365 | $ 410 | $ 465 | $ 470 |
| D7471 | Removal Of Exostosis | $ 225 | $ 255 | $ 290 | $ 310 |
| D7472 | Remove Torus Palatinus | $ 220 | $ 250 | $ 290 | $ 300 |
| D7473 | Remove Torus Mandibularis | $ 230 | $ 260 | $ 295 | $ 310 |
| D7485 | Reduce Osseous Tuberosity | $ 125 | $ 140 | $ 155 | $ 195 |
| D7510 | Abscess - Intraoral Incision | $ 65 | $ 70 | $ 80 | $ 100 |
| D7511 | Abscess - Intraoral Incision | $ 65 | $ 70 | $ 80 | $ 90 |
| D7520 | Abscess - Extraoral Incision | $ 105 | $ 115 | $ 135 | $ 160 |
| D7521 | Abscess - Extraoral Incision | $ 100 | $ 110 | $ 125 | $ 155 |
| D7921 | Collect - Apply Autologous Product | $ 105 | $ 120 | $ 135 | $ 175 |
| D7950 | Bone Grafts- Mandible Or Maxilla | $ 780 | $ 780 | $ 780 | $ 790 |
| D7951 | Sinus Augmentation-Lateral | $ 999 | $ 999 | $ 999 | $ 999 |
| D7952 | Sinus Augmentation - Vertical | $ 999 | $ 999 | $ 999 | $ 999 |
| D7953 | Bone Graft | $ 180 | $ 210 | $ 240 | $ 305 |

| | | | | | |
|---|---|---|---|---|---|
| D7960 | Frenulectomy - Separate | $ 125 | $ 140 | $ 160 | $ 205 |
| D7963 | Frenuloplasty | $ 125 | $ 135 | $ 155 | $ 180 |
| D7970 | Excision Hyperplastic Tissue | $ 140 | $ 160 | $ 180 | $ 205 |
| D7971 | Excise Pericoronal Gingiva | $ 65 | $ 70 | $ 80 | $ 100 |
| D7972 | Reduce Fibrous Tuberosity | $ 135 | $ 155 | $ 170 | $ 205 |
| D8210 | Removable Appliance Therapy | $ 270 | $ 305 | $ 345 | $ 350 |
| D8220 | Fixed Appliance Therapy | $ 270 | $ 305 | $ 345 | $ 350 |
| D9110 | Emergency Relief Of Pain | $ 20 | $ 20 | $ 25 | $ 30 |
| D9120 | Bridge Sectioning | $ 50 | $ 55 | $ 65 | $ 65 |
| D9223 | Deep Sedation/General Anes | $ 70 | $ 80 | $ 95 | $ 100 |
| D9243 | Intravenous Sedation | $ 65 | $ 70 | $ 80 | $ 90 |
| D9310 | Consultation | $ 45 | $ 50 | $ 60 | $ 65 |
| D9610 | Inject Drug - Therapeutic | $ 25 | $ 25 | $ 30 | $ 35 |
| D9612 | Multiple Therapeutic Drugs | $ 40 | $ 45 | $ 50 | $ 55 |
| D9910 | Apply Desensitizing Medicine | $ 20 | $ 20 | $ 25 | $ 25 |
| D9911 | Desensitizing Resin | $ 20 | $ 20 | $ 25 | $ 25 |
| D9930 | Post-Surgical Complications | $ 35 | $ 40 | $ 45 | $ 55 |
| D9932 | Clean Inspect Complete Upper | $ 40 | $ 45 | $ 55 | $ 65 |
| D9933 | Clean Inspect Complete Lower | $ 40 | $ 45 | $ 55 | $ 65 |
| D9934 | Clean Inspect Partial Upper | $ 40 | $ 45 | $ 55 | $ 65 |
| D9935 | Clean Inspect Partial Lower | $ 40 | $ 45 | $ 55 | $ 65 |
| D9940 | Occlusal Guards | $ 220 | $ 250 | $ 280 | $ 305 |
| D9942 | Repair / Reline Occlusal Guard | $ 70 | $ 80 | $ 90 | $ 95 |
| D9943 | Occlusal Guard Adjustment | $ 15 | $ 20 | $ 20 | $ 25 |
| D9951 | Adjust Occlusion - Limited | $ 35 | $ 40 | $ 45 | $ 50 |
| D9952 | Adjust Occlusion - Complete | $ 160 | $ 185 | $ 205 | $ 255 |

***Important Note***: Copayments listed may not represent the full extent of your out-of-pocket expense (e.g., some services may be subject to the Plan's alternate benefit provisions). It is strongly suggested that you obtain a pretreatment estimate of benefits before the services are rendered in order to better understand what services are covered by the Plan and receive an estimate of what the Plan will pay.

Copayments in the Copay Dental option vary depending on the geographic location of where the Covered Service is performed. The following is a list of the geographic locations that are included within each area (based on the first three digits of the 5-digit ZIP code).

| Area 1 | Area 2 |
|---|---|
| Alabama; for ZIP codes 350-352 and 354-369 | Arizona; for ZIP codes 850-853, 855-856, 859-860 and 863-865 |
| Arizona; for ZIP code 857 | Arkansas; for ZIP codes 718, 721 and 727 |
| Arkansas; for ZIP codes 716-717, 719-720, 722-726 and 728-729 | California; for ZIP codes 900-902, 905-908, 912-928, 936-938 and 953 |
| Florida; for ZIP codes 320-329, 333-337, and 344-347 | Colorado; for ZIP codes 800-815 |
| Georgia; for ZIP codes 307-309 and 312 | District of Columbia; for ZIP codes 202-205 |
| Illinois; for ZIP codes 600, 609-620, 622, and 624-629 | Florida; for ZIP codes 330-332, 338-339, 341-342 and 349 |
| Indiana; for ZIP codes 460-465, 469, and 471-478 | Georgia; for ZIP codes 300-306, 310-311, 313-319 and 398 |
| Iowa; for ZIP codes 500-501, 506-509, 512-515 and 520-528 | Hawaii; for ZIP codes 967-968 |
| Kansas; for ZIP codes 661, 667-669, 671, 673-677 and 679 | Idaho; for ZIP codes 832-838 |
| Kentucky; for ZIP codes 400-414, 416-418 and 421-427 | Illinois; for ZIP codes 601-608 and 623 |
| Louisiana; for ZIP codes 700-701, 703-708 and 710-714 | Indiana; for ZIP codes 466-468, 470 and 479 |
| Maryland; for ZIP codes 206, 212 and 215-218 | Iowa; for ZIP codes 502-505 and 516 |
| Michigan; for ZIP codes 486-487 | Kansas; for ZIP codes 660, 662, 664-666, 670, 672 and 678 |
| Minnesota; for ZIP codes 561-562 and 566-567 | Kentucky; for ZIP code 415 and 420 |
| Mississippi; for ZIP codes 386-395 | Maryland; for ZIP codes 207-211, 214 and 219 |
| Missouri; for ZIP codes 632-633, 635-641, 644-651 and 653-657 | Massachusetts; for ZIP codes 010, 012-013 and 026-027 |
| Nebraska; for ZIP codes 680-681 and 683-693 | Michigan; for ZIP codes 480-485, 488-497 and 499 |
| New York; for ZIP codes 104, 120-126, 140-143 and 147-149 | Minnesota; for ZIP codes 555-560, 563 and 565 |
| Ohio; for ZIP codes 430-450, 452-456 and 459 | Mississippi; for ZIP codes 396-397 |
| Oklahoma; for ZIP codes 730-731, 733-734, 736-741 and 743-749 | Missouri; for ZIP codes 630-631, 634, 652 and 658 |
| Pennsylvania; for ZIP codes 150-174, 180, 182-188 and 190-192 | Montana; for ZIP codes 590, 594 and 599 |
| Puerto Rico; for ZIP codes 006-007 and 009 | Nevada; for ZIP codes 889-891 |
| Tennessee; for ZIP codes 370-372, 374-375 and 378-385 | New Jersey; for ZIP codes 070-073, 077 and 080-087 |
| Texas; for ZIP codes 750-753, 755-782 and 785-799 | New Mexico; for ZIP codes 871-872, 875, 877 and 879-884 |
| Utah; for ZIP codes 840-847 | New York; for ZIP codes 103, 109-119, 127-139 and 144-146 |
| Virginia; for ZIP codes 224-225, 227, 230-233, 238-239, 241-244 and 246 | North Carolina; for ZIP codes 270, 283 and 285-286 |
| West Virginia for ZIP codes 247-248, 250-253, 255-257, 260 and 262-268 | North Dakota; for ZIP codes 582-583 and 585-588 |
| Wisconsin; for ZIP codes 538-540 and 548 | Ohio; for ZIP codes 451 and 457-458 |
| Wyoming; for ZIP codes 821-824, 827-828 and 830-831 | Oklahoma; for ZIP code 735 |
| | Pennsylvania; for ZIP codes 175-179, 181, 189 and 193-196 |
| | South Carolina; for ZIP codes 290-299 |
| | South Dakota; for ZIP codes 570 and 573-577 |
| | Tennessee; for ZIP codes 373 and 376-377 |
| | Texas; for ZIP codes 754, 783-784 and 885 |
| | Virgin Islands; for ZIP code 008 |
| | Virginia; for ZIP codes 201, 220-223, 226, 228-229, 234-237, 240 and 245 |
| | West Virginia; for ZIP codes 249, 258-259 and 261 |
| | Wisconsin; for ZIP codes 530-532, 534-535, 541-542, 544-547 and 549 |
| | Wyoming; for ZIP codes 820, 825-826 and 829 |

| Area 3 | | Area 4 |
|---|---|---|
| California; for ZIP codes 903-904, 910-911, 930, 932-935, 939, 945-946, 948, 950, 952, 954 and 956-961 | | Alaska; for ZIP codes 995-999 |
| Connecticut; for ZIP codes 060-061, 063-064 and 066-068 | | California; for ZIP codes 931, 940-944, 947, 949, 951 and 955 |
| D.C.: ZIP code 200 | | Colorado; for ZIP code 816 |
| Iowa; for ZIP codes 510-511 | | Connecticut; for ZIP codes 062, 065 and 069 |
| Maine; for ZIP codes 044 and 046-047 | | Delaware; for ZIP codes 197-199 |
| Massachusetts; for ZIP codes 011 and 014-025 | | Guam; for ZIP code 969 |
| Michigan; for ZIP code 498 | | Maine; for ZIP codes 039-043, 045 and 048-049 |
| Minnesota; for ZIP codes 550-551 and 553-554 | | Nevada; for ZIP codes 894-895 and 897-898 |
| Montana; for ZIP codes 595-598 | | New Hampshire; for ZIP codes 030-038 |
| Nevada; for ZIP code 893 | | Vermont; for ZIP codes 050-051 |
| New Jersey; for ZIP codes 074-076, 078-079 and 088-089 | | Washington; for ZIP codes 980-982 and 993 |
| New Mexico; for ZIP codes 870, 873-874, 878 | | Wisconsin; for ZIP code 537 |
| New York; for ZIP codes 100-102 and 105-108 | | |
| North Carolina; for ZIP codes 271-282, 284 and 287-289 | | |
| North Dakota: for ZIP codes 580-581, 584 | | |
| Oregon; for ZIP codes 970-979 | | |
| Rhode Island; for ZIP codes 028-029 | | |
| South Dakota; for ZIP codes 571-572 | | |
| Vermont; for ZIP codes 052-054 and 056-059 | | |
| Washington; for ZIP codes 983-986, 988, 992 and 994 | | |
| West Virginia; for ZIP code 254 | | |
| Wisconsin; for ZIP code 543 | | |

# Copay Dental – Covered Services

The Plan covers a portion of a Dentist's charge for Covered Services delivered to a Participant. To be a Covered Service, all of the following conditions must be satisfied:

- the service must be ordered or prescribed by a Dentist;
- the service must be Dentally Necessary; and
- the service must be within the scope of the Plan's coverage limitations.

The Plan will pay a portion of a Dentist's charge for a Covered Service (as set forth on the Schedule of Benefits) only if the following conditions are satisfied:

- the Deductible amount, if applicable, in the Schedule of Benefits has been met;
- the maximum benefit in the Schedule of Benefits has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefits provision; and
- for Type A, B or C covered services the service is started and completed while coverage is in effect.

The following section lists covered dental services. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to MetLife.

## Type A – Preventive and Diagnostic Covered Services

1. Oral exams twice in a Year.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, twice in a Year.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), twice in a Year.
4. Problem-focused exams.
5. Bitewing x-rays 2 sets in a Year.
6. Cleaning of teeth also referred to as oral prophylaxis (including full mouth scaling in presence of generalized moderate or severe gingival inflammation after oral evaluation) three timesin a Year.
7. Topical fluoride treatment for a Child under age 19, once in a Year.

## Type B – Basic Covered Services

1. Full mouth or panoramic x-rays once every 60 months.
2. Intraoral-periapical x-rays.
3. X-rays, except as mentioned elsewhere.
4. Pulp vitality and bacteriological studies for determination of bacteriologic agents.
5. Collection and preparation of genetic sample material for laboratory analysis and report, but no more than once per lifetime.
6. Diagnostic casts.
7. Emergency palliative treatment to relieve tooth pain.
8. Amalgam fillings.
9. Resin-based composite fillings.
10. Protective (sedative) fillings.

11. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty and osseous surgery) has been performed. Periodontal maintenance is limited to 2 times in any Year.
12. Pulp capping (excluding final restoration).
13. Pulp therapy.
14. Injections of therapeutic drugs.
15. Space maintainers for a Child under age 19.
16. Sealants or sealant repairs for a child under age 19, which are applied to non-restored, non-decayed first and second permanent molars, once per tooth every 3 Years.
17. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth every 3 Years.
18. Interim caries arresting medicament application applied to permanent bicuspids and first and second molar teeth, once per tooth every 3 Years.
19. Application of desensitizing medicaments where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed.

## Type C - Major Covered Services

1. Therapeutic pulpotomy (excluding final restoration).
2. Apexification/recalcification.
3. Pulpal regeneration, but not more than once per lifetime.
4. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when the Claims Administrator determines such anesthesia is necessary in accordance with generally accepted dental standards.
5. Local chemotherapeutic agents.
6. Initial installation of full or partial Dentures (other than implant supported prosthetics).
7. Addition of teeth to a partial removable Denture.
8. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 5 Years prior to replacement.
9. Replacement of a non-serviceable removable Denture if such Denture was installed more than 5 Years prior to replacement.
10. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
11. Other removable prosthetic services not described elsewhere.
12. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36-month period.
13. Re-cementing of Cast Restorations or Dentures.
14. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12-month period.
15. Initial installation of Cast Restorations (except implant supported Cast Restorations).

16. Replacement of any Cast Restoration (except an implant supported Cast Restoration) but only if at least a 5 Year period has passed since the most recent time that:
    - A Cast Restoration was installed for the same tooth; or
    - a Cast Restoration for the same tooth was replaced.
17. Prefabricated crown, but no more than one replacement for the same tooth surface within 5 Years.
18. Core buildup, but no more than once per tooth in a period of 5 Years.
19. Posts and cores, but no more than once per tooth in a period of 5 Years.
20. Fixed and removable appliances for correction of harmful habits.
21. Oral surgery, except as mentioned elsewhere in this summary plan description.
22. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12-month period.
23. Other consultations, but not more than twice in a 12-month period.
24. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery.
25. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
26. Periodontal scaling and root planing, but not more than once per quadrant in any 24-month period.
27. Full mouth debridements, but not more than once in any 3-Year period.
28. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period.
29. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
30. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
31. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 5-Year period.
32. Implant supported Cast Restorations, but no more than once for the same tooth position in a 5-Year period.
33. Implant supported fixed Dentures, but no more than once for the same tooth position in a 5-Year period.
34. Implant supported removable Dentures, but no more than once for the same tooth position in a 5-Year period.
35. Tissue conditioning, but not more than once in a 36-month period.
36. Simple repair of Cast Restorations or Dentures other than recementing.
37. Occlusal adjustments, but not more than once in a 12-month period.
38. Cleaning and inspection of a removable appliance three times in a Year.
39. Appliances for treatment for bruxism (grinding teeth), including but not limited to occlusal guards including adjustments and night guards.

## Type D Services – Orthodontic Covered Services

Covered Services include orthodontic work-up including x-rays, diagnostic casts, active treatment plan and retention appliances.

## Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $200, you have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After the Claims Administrator receives this information, the Claims Administrator will provide you with an estimate of the dental benefits available for the service. The estimate is not a guarantee of the amount this Plan will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that you choose. You are required to submit Proof on or after the date the dental service is completed in order for This Plan to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain this estimate. See “Preservice Determination” section for additional information.

# Copay Dental – Benefit Amounts

## Network Providers

If a Covered Service is provided by a Network Dentist, the maximum amount paid by the Plan is as follows:

- For Type A, B or C Covered Services, the Maximum Allowed Charge minus the required Copayment; or
- For Type D Covered Services, the Maximum Allowed Charge times the Covered Percentage specified in the Schedule of Benefits.

As explained under “Alternate Benefits,” below, the amount paid by the Plan may be reduced if the Claims Administrator determines that a less costly alternative was available.

In any case in which the Plan pays less than the Maximum Allowed Charge, you or your Dependent are responsible for the balance of the Maximum Allowed Charge.

## Out-of-Network Providers

If a Covered Service is provided by an Out-of-Network Dentist, the maximum amount paid by the Plan is the Maximum Allowable Charge times the Covered Percentage, minus the Deductible as specified in the Schedule of Benefits. As explained under “Alternate Benefits,” below, the amount paid by the Plan may be reduced if the Claims Administrator determines that a less costly alternative was available.

Out-of-Network Dentists may charge you more than the Maximum Allowed Charge. You will be responsible for paying:

- the Deductible;
- any part of the Maximum Allowed Charge for which this Plan does not pay benefits; and
- any amount that the Out-of-Network Dentist charges in excess of the Maximum Allowed Charge.

## Orthodontics

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia in effect when the course of treatment begins.

The benefit for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental benefits are in effect for the person receiving the orthodontic treatment; and
- Proof is given to the Claims Administrator that the orthodontic treatment is continuing.

If the initial placement was made before these dental benefits went into effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits started before these dental benefits went into effect:

- the number of months for which benefits are payable will be reduced by the number of month of treatment performed before thee dental benefits were in effect: and
- The total amount of the benefit payable for the periodic visits will be reduced proportionately.

## Alternate Benefits

If the Claims Administrator determines that a dental condition could have been treated by performing a service that costs less than the Covered Service the Dentist performed, this Plan will pay benefits based upon the less costly service if the Claims Administrator determines that the less costly service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Claims Administrator may base the benefit determination upon the amalgam filling, which is the less costly service;
- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling, which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, the Claims Administrator may base the benefit determination upon the filling, which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, the Claims Administrator may base the benefit determination upon the partial denture, which is the less costly service.

If this Plan pays benefits based upon a less costly service in accordance with this subsection, the Dentist may charge you or your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by a Network Dentist.

## Multi-Step Services

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this summary plan description, separate steps of one service are considered to be part of the more comprehensive service. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, the Plan will pay benefits only for the root canal therapy.

## Maximum Benefit Amounts

This Plan will pay for Covered Services received, both Network and Out-of-Network, but will never pay more than the greater of the Network calendar Year maximum or the Out-of-Network calendar Year maximum. For Type D Covered Services, the Plan will never pay more than the lifetime maximum benefit.

# Avnet, Inc. Dental Plan

## Benefits This Plan Will Pay After Coverage Ends

In general, the Plan does not pay benefits for services performed after your coverage ends. However, as explained below, special rules apply for completing the installation of a prosthetic device, installation of a Cast Restoration, and root canal therapy.

This Plan will pay benefits for up to 31 days after your coverage ends for completing the installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before your coverage ends; and
- the device is installed within 31 days after the date the coverage ends.

This Plan will pay benefits for up to 31 days after your coverage ends for completing the installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before your coverage ends; and
- the Cast Restoration is installed within 31 days after the date the coverage ends.

This Plan will pay benefits for up to 31 days after your coverage ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before your coverage ends; and
- the treatment is finished within 31 days after the date the coverage ends.

## Expenses Not Covered

This Plan will not pay dental benefits for charges incurred for:

1. services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which this Plan deems experimental in nature;
2. services for which you would not be required to pay in the absence of dental benefits;
3. services or supplies received by you or your Dependent before the dental benefits start for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counselling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;

13. services that are:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is not required to pay; or
    - received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Employer, such as your group health plan;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. fixed and removable appliances for correction of harmful habits (applies only to PPO Dental)
24. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
25. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
26. duplicate prosthetic devices or appliances;
27. replacement of a lost or stolen appliance, Cast Restoration or Denture;
28. replacement of an orthodontic device
29. diagnosis and treatment of temporomandibular joint disorders and cone beam imaging associated with the treatment of temporomandibular joint disorders; or
30. intra and extraoral photographic images.

## General Limitations

No payment will be made for dental expenses incurred for you or any one of your Dependents:

- for or in connection with an injury or sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a facility owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared, riot or insurrection;

- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no coverage;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule of Benefits;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

# Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one plan and determines how benefits payable from all such plans will be coordinated. You should file all claims with each plan.

**Definitions**

For the purposes of this section, the following terms have the meanings set forth below:

**Plan**

A plan means any of the following that provides benefits or services for dental care or treatment:

1. Group insurance and/or group-type coverage, whether insured or self-insured if it cannot be purchased by the general public, or is individually underwritten, including closed panel coverage.
2. Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
3. Medical benefits coverage of group, group-type, and individual automobile contracts.
4. Each plan or part of a plan which has the right to coordinate benefits will be considered a separate plan. For example, this Plan is treated as separate from other benefit options under the Avnet Group Benefits Plan.

**Closed Panel Plan**

A plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

**Primary Plan**

The plan that determines and provides or pays benefits without taking into consideration the existence of any other plan.

**Secondary Plan**

A plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

**Allowable Expense**

A necessary, reasonable and customary service or expense, including deductibles and coinsurance, that is covered in full or in part by any plan covering a Participant. When a plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is treated a paid benefit.

Examples of expenses or services that are not Allowable Expenses include the following:

- An expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense.
- If you are covered by two or more plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one plan that provides services or supplies on the basis of reasonable and customary fees and one plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense.

**Claim Determination Period**

A calendar Year, but does not include any part of a Year during which you are not covered under this Plan or any date before this section or any similar provision takes effect.

**Reasonable Cash Value**

An amount that a duly licensed provider of dental services usually charges patients and that is within the range of fees usually charged for the same service by other dental providers located within the immediate geographic area where the dental service is rendered under similar or comparable circumstances. The Reasonable Cash Value is determined by the Claims Administrator.

**Order of Benefit Determination Rules**

A plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The plan that covers you as an enrollee or an employee shall be the Primary Plan and the plan that covers you as a Dependent shall be the Secondary Plan.
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the plan which covers the parent whose birthday falls first in the calendar Year as an enrollee or employee.
3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
    a. first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
    b. then, the plan of the parent with custody of the child;
    c. then, the plan of the Spouse of the parent with custody of the child;
    d. then, the plan of the parent not having custody of the child, and
    e. finally, the plan of the Spouse of the parent not having custody of the child.
4. The plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.

5. The plan that covers you under a right of continuation which is provided by federal or state law (*e.g.*, COBRA coverage) shall be the Secondary Plan and the plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other plan does not have a similar provision and, as a result, the plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the plans determines the order of benefits based upon the gender of a parent, and as a result, the plans do not agree on the order of benefit determination, the plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, except to the extent required by federal Medicare Secondary Payer rules, this Plan will be the Secondary Plan and determine benefits after Medicare. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

When coordinating benefits with the State Children's Health Insurance Program (SCHIP) for services provided under this Plan which are also provided under SCHIP, this Plan will be the Primary Plan and will determine benefits before SCHIP.

**Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all plans combined during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses during that period.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. MetLife will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, MetLife will determine the following:

1. This Plan's obligation to provide services and supplies;
2. whether a benefit reserve has been recorded for you; and
3. whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, MetLife will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

**Payment Made by Another Plan**

If a payment made under another plan includes an amount that should have been paid under this Plan, this Plan may reimburse the other plan. The reimbursed amount will then be treated as though it were a benefit paid under this Plan, and this Plan will not have to pay that amount again. The term "payment made" includes benefits provided in the form of services, in which case this Plan may pay the Reasonable Cash Value of the benefits provided in the form of services.

**Right to Receive and Release Information**

MetLife and the Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide MetLife and the Plan Administrator with any information it requests in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment.

# Right of Recovery

**The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:**

- Made in error.
- Due to a mistake in fact.
- Advanced during the time period of meeting the calendar year Deductible.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan may recover the overpayment from you. See “Overpayments” below.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- Submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan.
- Conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

# Payment of Benefits

## To Whom Payable

All dental benefits are payable to the Participant. However, you may assign dental benefits to the Dentist providing the relevant service. If this happens, this Plan will pay benefits directly to the Dentist.

When benefits are paid to you or your Dependent, you are responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of MetLife, or the Plan Administrator, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, MetLife may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, MetLife or the Plan Administrator may choose to make direct payment to any of your following living relatives: Spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release MetLife and the Plan from all liability to the extent of any payment made.

## Time of Payment

Benefits will be paid by MetLife (on behalf of the Plan) when it receives due Proof of loss.

## Overpayments

This Plan has the right to recover any amount that the Claims Administrator determines to be an overpayment, whether for services received by you or by a Dependent. An overpayment occurs if the Claims Administrator or the Plan Administrator determines that:

- the total amount paid by this Plan on a claim for dental benefits is more than the total of the benefits due to you under this Plan; or
- payment this Plan made should have been made by another plan.

If an overpayment occurs, you must reimburse this Plan. This Plan may recover the overpayment from you by:

- stopping or reducing any future benefits payable for dental benefits;
- demanding an immediate refund of the overpayment from you; and
- taking legal action.

If an overpayment results from this Plan having made a payment to you that should have been made under another group plan, this Plan may recover the overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

This right is in addition to all other rights that MetLife, the Plan, the Company, and their affiliates have at law and in equity (including the subrogation and reimbursement rights described above).

Upon request, you must execute and deliver to MetLife and the Plan such instruments and documents as MetLife or the Plan Administrator determines are necessary to secure the right of recovery.

# Termination of Plan Coverage

## Employees

Your Plan coverage will cease on the earliest date below:

- the date you cease to be in a class of eligible Employees or cease to qualify for Plan coverage;
- the last day for which you have made any required contribution for Plan coverage;
- the date the Plan is terminated;
- the date of your death; or
- the last day of the month in which your Active Service ends except as described below.

## Leave of Absence

If your Active Service ends due to a leave of absence, your coverage will be continued until the earlier of (a) the last day of the month after 12 months from the start of your leave or (b) the last day of the month after the termination of your employment. Coverage is continued up to two years for Military Leave (for more details, see “Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA),” below).

Under no circumstances will coverage under the Plan continue past the date specified by the Company, unless required by applicable law.

You must continue paying required contributions for Plan coverage during any absence. If you take an unpaid leave, you have the option to pre-pay, pay as you go, or pay upon your return from leave. Please contact the Benefits department for more information and to arrange for payment during an unpaid leave.

## Dependents

Coverage for all of your Dependents will end on the earliest date below:

- the date your Plan coverage ends (without regard to any of the special Plan continuation coverage rules summarized in this booklet).
- the date you cease to be eligible for Dependent coverage.
- the last day for which you have made any required contribution for the coverage.
- the date Dependent coverage is canceled.

Coverage for each individual Dependent will end on the date the Dependent no longer qualifies as a Dependent. However, benefits for a Dependent child will continue until the last day of the month in which your Dependent reaches the limiting age.

## Cancellation of Coverage for Submitting False or Fraudulent Claims

If a Participant submits a false or fraudulent Plan claim, or knowingly participates in a transaction or arrangement with others that leads to the submission of a false or fraudulent Plan claim by others (such as a Dental Service provider), the Plan reserves the right to revoke coverage under the Plan for the Participant and any related Dependent or Employee. Any decision made to revoke Plan coverage may apply retroactively and will be determined by the Avnet Executive Board (AEB). A person whose coverage under the Plan was revoked may appeal the decision to the AEB. The AEB will also decide if, and when, coverage may resume under the Plan or another group dental plan sponsored by the Company.

***Important Note:*** If MetLife and/or Avnet, Inc. find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact Avnet, Inc. has the right to rescind coverage and demand that you pay back all Benefits Avnet, Inc. paid to you, or paid in your name, during the time you were incorrectly covered under the Plan. Submitting a false, fraudulent, or misleading claim may be a crime punishable by fines or prison.

# Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations.

## Notice of Provider Directory/Networks

Your participating provider network (PDP or PDP Plus) consists of a group of local dental practitioners, of varied specialties as well as general practice, who are contracted with MetLife.

You can obtain a listing of MetLife's Network Dentists either by calling 800-942-0854 or by visiting MetLife's website at www.metlife.com/dental.

## Qualified Medical Child Support Order (QMCSO)

A qualified medical child support order (QMCSO) is a judgment, decree, or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, the child covered by the QMCSO will be eligible for the coverage required by the order. You must notify the Company and elect coverage for that child, and yourself if you are not already enrolled, within 30 days after the QMCSO is qualified by the Plan.

Generally, a QMCSO may not require the Plan to provide coverage for any type or form of benefit or option not otherwise provided under the Plan.

Any payment of benefits in reimbursement for Covered Health Services paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child. You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

***Important Note:*** A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

## Changing Your Coverage Election

Any coverage that you elect under the Plan (including an election not to be covered by the Plan) will remain in effect through the end of the calendar Year for which it applies. Your election may not be changed during the Year unless one of the special circumstances described below applies to you. If one of the special circumstances applies, your change must be made within 30 days and will be effective prospectively only.

## Change in Status

Section 125 of the Internal Revenue Code allows you to make premium payments on a pre-tax basis (subject to certain exceptions), provided that the Plan complies with certain requirements. The Plan is subject to those requirements, which are described below.

**Coverage Elections**

You are generally allowed to enroll for coverage only within 30 days of your date of hire or change coverage only during the annual Open Enrollment period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet the HIPAA special enrollment criteria described below; or
- the date you qualify to make a change under one of the following sections.

**Change in Status**

The Section 125 rules allow new enrollment or coverage elections in response to (and consistent with) any of the following changes in status:

- change in legal marital status due to marriage, death of a Spouse, divorce, annulment, or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, legal guardianship of a child, or death of a Dependent;
- change in employment status of you, your Spouse, or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- change in employment status of you, your Spouse, or Dependent resulting in eligibility or ineligibility for coverage (e.g., reduction in hours), as long as the change corresponds to your intended enrollment (and the intended enrollment of any related individuals whose coverage is being dropped) in other minimum essential coverage;
- change in residence of you, your Spouse, or Dependent to a location outside of the Employer's network service area;
- change that causes a Dependent to become eligible or ineligible for coverage; and
- change in employment status that causes the average number of hours that you are expected to work to decrease below 30 hours of service per week, and you certify that you (and your Spouse and Dependent, if applicable) will enroll in other minimum essential coverage that is effective by the first day of the second month after the month in which your drop your medical coverage.

**Court Order**

You may make a change in coverage in order to comply with a court or administrative order (e.g., Qualified Medical Child Support Order).

**Changes to Coverage**

If the cost of benefits increases or decreases during a benefit period, the Company may automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

**Changes in Coverage of Spouse or Dependent Under Another Employer's Plan**

You may make a coverage election change if the Plan of your Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to special enrollment, change in status, or court order; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

## Family and Medical Leave Act of 1993 (FMLA)

Special rules apply if you take a leave for family or medical reasons that qualifies for protection under the FMLA.

**Continuation of Health Coverage During Leave**

Your Plan coverage will be continued during a leave of absence if:

- that leave qualifies for protection under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the FMLA.

The cost of your Plan coverage during such leave is shared by you and your Employer. You have the option to pre-pay, pay as you go, or pay upon your return from leave. Please contact the Benefits department at 888-99-HR NOW (888-994-7669), to arrange payment of your continued health coverage.

## Reinstatement of Canceled Coverage Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the FMLA, any canceled insurance (health, life or disability) will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period, to the extent that they had been satisfied prior to the start of such leave of absence.

More information about the FMLA is posted on the Avnet Benefits intranet.

## Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

Special rules apply if you take a military leave that qualifies for protection under USERRA. The requirements summarized below apply only to coverage for you and your Dependents under this Plan. (Different rules apply for other benefits.)

For more information about whether a leave will be treated as a “qualified military leave” or about your rights under USERRA, please refer to the military leave policy posted on the Avnet Benefits intranet.

**Continuation of Plan Coverage**

For qualified military leaves of 30 days or less, Plan coverage will continue as if you remained in Active Service on short-term unpaid leave. You will have to pay for the Employee portion of Plan coverage for you and your Dependents.

After 30 days, Plan coverage for yourself and your Dependents will continue unless you notify the Company that you are going on qualified military leave and request that your Plan coverage be discontinued. You will have to pay for the Employee portion of Plan coverage for you and your Dependents.

The Company will use rules similar to those that apply under the COBRA Continuation Coverage rules (described below) for purposes of determining whether you have made timely required monthly payments for Plan coverage.

Your may continue coverage during a qualified military leave until the earliest of the following:

- The second anniversary of your last day of Active Service with the Company;
- the day after the deadline by which you must return to work with the Company in order to qualify for USERRA protection if you do not return to work with the Company by that deadline;
- the first day of a month for which your Plan coverage payment is late by more than 30 days;
- the date that your coverage would otherwise terminate under the Plan (such as for submitting a fraudulent claim); or
- the date the Company terminates all its group medical plans.

**Reinstatement of Benefits (applicable to all coverages)**

If your coverage ends during the leave of absence because you elect not to continue coverage as permitted by USERRA (or because you do not elect an available conversion plan at the expiration of USERRA coverage) and you are reemployed by the Company, coverage for you and your Dependents may be reinstated if (a) you gave the Company advance written or verbal notice of your qualified military service leave, (b) your qualified military leave was for not more than 5 years, and (c) you return to work with the Company before your USERRA rights expire.

You and your Dependents will be subject to only the balance of any waiting period that was not yet satisfied before the leave began.

If your coverage under this Plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service starts, these reinstatement rights will continue to apply.

# Claim Determination Procedures

## Procedures for Initial Claim

Your claim for dental benefits can be submitted by your Dentist online at www.metdental.com or by you on the specified claim form. You can print a claim form from the Avnet Benefits intranet or download a copy from www.metlife.com/dental. You may also request a copy by contacting MetLife at 800-942-0854. You should receive the claim form within 15 days of requesting it. If you do not receive a claim form within 15 days, Proof may be sent using any form sufficient to provide the Claims Administrator with the required Proof.

You must submit a copy of your itemized bill with your claim for benefits. If not indicated on your itemized bill, your claim must also describe the occurrence, character and extent of the service or charge for which claim is made. Be sure to use your Social Security number and Avnet account number (#305519) on the claim form.

All fully completed claim forms and bills should be sent to:

**MetLife Dental Claims**
**P.O. Box 981282**
**El Paso, TX 79998-1282**
**Fax: 859-389-6505**

When the Claims Administrator receives the Proof, the Claims Administrator will review the claim. If the claim is approved, this Plan will pay the dental benefits in effect on the date that service was completed.

If you have a question about a claim payment, you may request an explanation from the Claims Administrator by dialing 800-942-0854.

## Procedures Regarding Dental Necessity Determinations

In general, dental services must be Dentally Necessary to be covered under the Plan. The procedures for determining dental necessity vary, according to the type of service or benefit requested, and the type of plan. Dental necessity determinations are made on a preservice or postservice basis, as described below.

## Preservice Determinations

You may, but are not required to, obtain authorization before you incur a dental expense. This prior authorization is called a “pretreatment estimate of benefits.” When you or your representative request preservice determination, MetLife will notify you or your representative of the determination within 15 days after receiving the request. If more time is needed due to matters beyond MetLife's control, MetLife will notify you or your representative within 15 days after receiving your request.

This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to MetLife within 45 days after receiving the notice. The determination period will be suspended on the date MetLife sends a notice of missing information, and will resume when you or your representative responds to the notice (or, if earlier, on your deadline for responding).

If the determination periods above would (a) seriously jeopardize your life or health or your ability to regain maximum function (as determined by MetLife), or (b) in the opinion of a Dentist or Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, MetLife will make the preservice determination on an expedited basis. See “Urgent Care Claim Submission” section below for additional information.

If you or your representative fails to follow MetLife's procedures for requesting a preservice determination, MetLife will notify you or your representative of the failure and describe the proper procedures for filing within 5 days after receiving the request. This notice may be provided orally, unless you or your representative requests Written notification.

## Urgent Care Claim Submission

A small number of claims for dental benefits may be urgent care claims. Urgent care claims for dental benefits are claims related to services which a Dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course, any such claim may always be submitted in accordance with the normal claim procedures. However, your Dentist may also submit such a claim to the Claims Administrator by telephoning the Claims Administrator and informing the Claims Administrator that the claim is an urgent care claim.

Urgent care claims are processed according to the procedures set out above, except that the Claims Administrator will notify you of the determination on the claim no later than 72 hours after the claim was filed. If you or your covered Dependent does not provide the Claims Administrator with enough information to decide the claim, the Claims Administrator will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, the Claims Administrator will then notify you of the claim decision within 48 hours after the Claims Administrator received the information. If the needed information is not provided, the Claims Administrator will notify you or your covered Dependent of its decision within 72 hours after the deadline for providing the information (generally within 120 hours after the claim was received).

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in Writing. The Claims Administrator will provide you any necessary information to assist you in your appeal. The Claims Administrator will then notify you of its decision within 72 hours of your request in Writing. However, the Claims Administrator may notify you by phone within the time frames above and then mail you a written notice.

## Postservice Determinations

When you or your representative requests a dental necessity determination after services have been rendered, MetLife will notify you or your representative of the determination within 30 days after receiving the request. If more time is needed to make a determination due to matters beyond MetLife's control, MetLife will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If an extension is needed because you did not provide sufficient information or filed an incomplete claim, you or your representative must provide the specified information to MetLife within 45 days after receiving the notice. The determination period will be suspended on the date MetLife sends the notice of missing information, and will resume when you or your representative responds to the notice (or, if earlier, on your deadline for responding).

## Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in Writing, and will include all of the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the Plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim, including why the additional material or information is necessary; a description of the Plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final appeal; and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a dental necessity, experimental treatment or other similar exclusion or limit.

## Appealing the Initial Determination

If the Claims Administrator denies your claim, you may make two appeals of the initial determination. Upon your written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to the Claims Administrator at the address indicated on the claim form within 180 days of receiving the Claims Administrator's decision. Appeals must be in Writing and must include the following information:

- Name of Employee
- Name of this Plan
- Reference to the initial decision
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why you are appealing the initial determination

As part of each appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After the Claims Administrator receives your written request appealing the initial determination or determination on the first appeal, the Claims Administrator will conduct a full and fair review of your claim. Deference will not be given to initial denials, and the Claims Administrator's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, the Claims Administrator will consult with a healthcare professional with appropriate training and experience in the field of dentistry involved in the judgment. This healthcare professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

The Claims Administrator will notify you in Writing of its final decision within 30 days after the Claims Administrator's receipt of your written request for review, except that under special circumstances the Claims Administrator may have up to an additional 30 days to provide written notification of the final decision. If such an extension is required, the Claims Administrator will notify you prior to the expiration of the initial 30-day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

If the Claims Administrator denies the claim on appeal, the Claims Administrator will send you a final Written decision that states the reason(s) why the claim you appealed is being denied and references any Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criteria was relied upon in denying the claim on appeal, the final Written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. In addition, if a determination is based on a Dental Necessity, experimental treatment or other similar exclusion or limit, the final Written decision will identify the applicable exclusion or limit and state that you may request a copy free of charge. Upon written request, the Claims Administrator will provide you free of charge with copies of documents, records and other information relevant to your claim.

If you are not satisfied with the decision on review (after the level-two appeal), you have the right to bring a civil action under Section 502(a) of ERISA. You or your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the Claims Administrator.

## Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) 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; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making

the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether statement or guidance was relied upon in making the benefit determination.

### Legal Action

Under ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. Before bringing an action, you must have submitted a Level-One appeal and Level-Two appeal.

### Arbitration

To the extent permitted by law, any controversy other than a claim or appeal between MetLife, the Company or the Plan and any Participant (or any legal representative acting on behalf of one or more Participants under the Plan), arising out of or in connection with the Plan, must be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within the 15-working-day-period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, the hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his/her (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

### Period for Bringing a Legal Action/Governing Law

No legal action (including filing a lawsuit or seeking arbitration) may be brought against the Plan, the Company, MetLife or any of their affiliates in connection with the Plan, after the earlier of: (A) 12 months after the date when a Participant has completed the last appeal process under the Plan or (B) 24 months after the Participant was notified in Writing that the Plan will not cover all or a portion of the claimed benefits that are the subject of the legal action. If the 24-month period would otherwise expire while a Participant is still actively seeking resolution of a claim through the Plan's appeal process, it will be extended for an additional 90 days until the final appeal process has been completed. If you miss the Plan's deadline for filing any required claim or appeal, you will forfeit your right to bring a legal action.

This Plan shall be interpreted in accordance with the laws of the State of Arizona (disregarding any conflicting rules that might point to the laws of another jurisdiction) to the extent that those laws are not superseded by federal law. In general, ERISA preempts state laws that relate to the Plan.

## COBRA Continuation Rights Under Federal Law

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this summary plan description or contact the Plan Administrator listed at the end of this section.

**What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. You will receive more information about premiums after you experience a qualifying event. In general, you will be charged 102% of the total cost for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your Spouse dies;
- Your Spouse's hours of employment are reduced;
- Your Spouse's employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

**When is COBRA Continuation Coverage Available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator (Avnet) within 60 days after the qualifying event occurs.** You should use the address or phone number

provided under "Plan Contact Information" at the end of this section.

**How is COBRA Coverage Provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or a reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

***Disability Extension of 18-month Period of COBRA Continuation Coverage***

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify the Plan Administrator in writing of Social Security's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Failure to provide this notice within 60 days means that you may not be offered the COBRA disability extension.

***Second Qualifying Event Extension of 18-month Period of Continuation Coverage***

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the Spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the Spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**If You Have Questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator listed at the end of this section. For more information about your rights under ERISA, including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.)

**Keep Your Plan Informed of Address Changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**

**Plan Administrator**
**Avnet, Inc.**
**2211 South 47th St.**
**Phoenix, AZ 85034**
**800-882-8638, option #4**

# Privacy Rights under the Health Insurance Portability and Accountability Act ("HIPAA")

The Plan is required to provide you with a notice that describes your rights and the Plan's obligations regarding your "protected health information." Generally, "protected health information" is individually identifiable health information, including demographic information, collected from you or created or received by a healthcare provider, a healthcare clearinghouse, the Plan, or your Employer on behalf of the Plan.

You were provided with a copy of the Plan's Notice of Privacy Practices when you first enrolled in the Plan and you will be provided with a copy following any material revisions. You can also request a copy of the Notice of Privacy Practices at any time by contacting the Plan Administrator listed below.

The Plan's HIPAA privacy provisions are set forth in Appendix A of this booklet.

# ERISA Required Information

## Plan Sponsor and Administrator

Avnet, Inc. is the Plan Sponsor and Plan Administrator of the Avnet Group Benefits Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

**Plan Administrator – Dental Plan**
**Avnet, Inc.**
**2211 S 47th St.**
**Phoenix, AZ 85034**
**800-882-8638, Option #4**

## Claims Administrator

MetLife is the Plan's Claims Administrator (Dental benefits only) for Covered Persons who reside within the United States.

The role of MetLife is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative services agreement with the Company. MetLife shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. MetLife shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan. You may contact the Claims Administrator at:

**MetLife Dental Claims**
**P.O. Box 981282**
**El Paso, TX 79998-1282**
**800-942-0854**

## Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

**Agent for Legal Process – Dental Plan**
**Avnet, Inc.**
**2211 S 47th St.**
**Phoenix, AZ 85034**

Legal process may also be served on the Plan Administrator. The office designated to consider the appeal of denied claims is:

**MetLife, Group Claims Review**
**P.O. Box 14589**
**Lexington, KY 40512**

## Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

## Type of Administration

The Plan is a self-funded welfare plan and the administration is provided through one or more third-party administrators.

| | |
|---|---|
| **Plan Name:** | Avnet Group Benefits Plan |
| **Plan Number:** | 510 |
| **Employer ID:** | 11-1890605 |
| **Plan Type:** | Welfare benefits plan |
| **Plan Year:** | January 1 – December 31 |
| **Plan Administration:** | Self-Insured |
| **Source of Plan Contributions:** | Employee and Company |
| **Source of Benefits:** | General assets of the Company |

## Collective Bargaining Agreements

The Plan is not currently maintained pursuant to a collective bargaining agreement. For more information, please contact the Plan Administrator.

## Discretionary Authority

The Plan Administrator has discretionary authority to interpret the terms of the Plan, including to resolve ambiguities and inconsistencies. The Plan Administrator delegates to MetLife the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include the determination of the eligibility of persons desiring to enroll in or claim benefits under the Plan, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. Pursuant to the terms of an administrative service agreement, the Plan Administrator delegates to MetLife the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

## Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right, at any time and for any reason, to change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, and by which part or all of the Plan may be terminated, is through the unilateral action of the Avnet Executive Board (AEB) or the Board of Directors of the Company. No consent of any Participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any Covered Expenses incurred or approved prior to the date the Plan terminates.

## Statement of Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

- Continue healthcare coverage for yourself, your Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

## Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people 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, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court (subject to the rules in the "Arbitration" section, above). The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# Definitions

**Active Service**

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on that day.
- on a day that is not one of your Employer's scheduled work days (*e.g.*, a weekend or holiday) if you were in Active Service on your Employer's last preceding scheduled work day.

**Cast Restoration**

An inlay, onlay or crown.

**Claims Administrator**

The Claims Administrator is Metropolitan Life Insurance Company ("MetLife"), New York, New York. MetLife does not insure the benefits described in this summary plan description.

**Company**

Avnet, Inc.

**Contributions**

The amount that the Employer requires you to pay as your portion of the cost of coverage. For active Employees, contributions are taken through payroll deductions.

**Copayment**

In the Copay Dental option, the dollar amount you pay to your Dentist for Covered Services performed by a Network Dentist. The Copayment amount is shown in the Copay schedule included in this summary plan description.

**Covered Percentage**

In the PPO Dental option, the Covered Percentage for a Covered Service performed by a Network Dentist is the percentage of the Maximum Allowed Charge that this Plan will pay for such services after any required Deductible is satisfied. For a Covered Service performed by an Out-of-Network Dentist, the Covered Percentage is the percentage of the Reasonable and Customary Charge that this Plan will pay for such services after any required Deductible is satisfied.

In the Copay Dental option, the percentage of the Maximum Allowed Charge that this Plan will pay for a Covered Service performed by an Out-of-Network Dentist after any required Deductible is satisfied is the Covered Percentage.

**Covered Service**

To be a Covered Service, all of the following conditions must be satisfied:

- the service must be ordered or prescribed by a Dentist;
- the service must be Dentally Necessary; and
- the service must be within the scope of the Plan's coverage limitations.

**Deductible**

The amount you or your Dependents must pay before this Plan will pay for Covered Services performed by an Out-of-Network Dentist.

**Dental Hygienist**

Person trained to remove calcareous deposits and stains from the surfaces of teeth; and provide information

on the prevention of oral disease. The term does not include you, your Spouse, or any member of your immediate family, including your and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents; or grandchildren.

**Dentally Necessary**

A dental service or treatment must be Dentally Necessary and performed in accordance with generally accepted dental standards, as determined by the Claims Administrator, and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

**Dentist**

A person licensed to practice dentistry in the jurisdiction where such services are performed. It also includes any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of this Plan. Each such person must be licensed in the jurisdiction where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required by such jurisdiction. The term does not include you, your Spouse, or any member of your immediate family, including your and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents; or grandchildren.

For purposes of dental benefits, the term will include a Physician who performs a Covered Service.

**Dentures**

Fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

**Dependent**

For purposes of the Plan, any of the following:

- your lawful Spouse; and
- any child of yours who is (a) less than 26 years old or (b) primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence must be submitted to MetLife within 31 days after the child's 26th birthday and at reasonable intervals after such date.

The term child means a child born to you, a child legally adopted by you, a child for whom you are a legal guardian, or a stepchild.

Benefits for a Dependent child will continue until the last day of the month in which your Dependent reaches the limiting age.

Anyone who is enrolled as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

**Employee**

A regular employee of the Employer who normally works an average of at least 20 hours per week and is currently in Active Service. An Employee must live and/or work in the United States.

An eligible Employee does not include any employee who:

- is temporary (*e.g.*, a seasonal intern) or classified by the Employer as a leased employee or independent contractor;
- is part-time and works an average of less than 20 hours per week for the Employer;
- is covered by a collective bargaining agreement, unless the collective bargaining agreement provides for eligibility under this Plan;
- is employed by a business unit or division that is not eligible to participate in the Plan; or
- does not have U.S.-source income.

If an individual who is classified as ineligible is subsequently reclassified (*e.g.*, an individual classified as an independent contractor is reclassified as an employee), the reclassification will apply prospectively only. Reclassification, whether by Avnet, a court, or otherwise, shall not result in retroactive coverage for any individual.

**Employer**

Avnet, Inc. or an Avnet company that has been designated as a participating employer. As of January 1, 2017, the only Employers other than Avnet, Inc. are AVT Technology Solutions, LLC, Avnet Government Solutions, LLC, and ExitCertified Corp.

AVT Technology Solutions, LLC, Avnet Government Solutions, LLC, and ExitCertified Corp. ceased to be a member of the Avnet controlled group as of February 27, 2017. However, pursuant to the Second Global Amendment, certain Employees and their eligible dependents who were participating in the Plan as of February 27, 2017 may continue to participate in the Plan through the Transition Period, as defined in the Second Global Amendment.

**ERISA**

The Employee Retirement Income Security Act of 1974, as amended.

**Including**

The term including means “including, but not limited to.” The term “include” has a comparable meaning.

**Maximum Allowed Charge**

The lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the Network Dentist has agreed with MetLife to accept as payment in full for the dental service.

**Medicaid**

A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

**Medicare**

The program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

**Network Dentist**

A Dentist, or a professional corporation, professional association, partnership, or other entity that participates in the Preferred Dentist Program (PDP and/or PDP Plus Network) and has a contractual agreement with MetLife to accept the Maximum Allowed Charge as payment in full for covered dental services. The providers qualifying as Network Dentists may change from time to time.

**Out-of-Network Dentist**

A Dentist who does not participate in the Preferred Dentist Program (PDP and/or PDP Plus Network) in considered Out-of-Network.

**Participant**

Any Employee or Dependent who has enrolled in, and is covered under, the Plan.

**Patient Protection and Affordable Care Act of 2010 (“PPACA”)**

PPACA (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and subsequent legislation.

**Physician**

A Physician is defined as follows:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the group benefits. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include you, your Spouse, or any member of your immediate family including your and/or your Spouse's parents, children (natural, step or adopted), siblings, grandparents, or grandchildren.

**Plan**

The Avnet, Inc. Dental Plan, which is offered as part of the Avnet Group Benefits Plan.

**Plan Administrator**

Avnet, Inc.

**Proof**

Proof is written evidence satisfactory to the Claims Administrator that a person has satisfied the conditions and requirements for any benefit described in this summary plan description. When a claim is made for any benefit described in this summary plan description, Proof must establish:

- the nature and extent of the loss or condition;
- this Plan's obligation to pay the claim; and
- the claimant's right to receive payment.
- Proof must be provided at the claimant's expense.

**Reasonable and Customary Charge**

In the PPO Dental option, the Reasonable and Customary Charge is the lowest of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) (the "Actual Charge"); or
- the usual charge by the Dentist or other provider of the services or supplies for the same or similar services or supplies (the "Usual Charge"); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 90th percentile of charges as determined by the Claims Administrator based on charge information for the same or similar services or supplies maintained in the Claims Administrator's Reasonable and Customary Charge records (the "Customary Charge"). Where the Claims Administrator determines that there is inadequate charge information maintained in the Claims Administrator's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

An example of how the 90th percentile is calculated is to assume one hundred (100) charges for the same service are contained in the Claims Administrator's Reasonable and Customary charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 90th percentile of charges is the charge that is equal to the charge numbered 90.

**Signed**

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to the Claims Administrator, and consistent with applicable law.

**Spouse**

A Spouse, for purposes of the Plan, is an individual to whom an Employee is lawfully married. In accordance with IRS Revenue Ruling 2013-17, an individual to whom an Employee is married will be recognized as the Employee's Spouse if (and only if) the marriage to that individual was legal and valid when it was entered into, under the laws of the jurisdiction where it was entered into.

A Spouse does not include a domestic partner or a partner through civil union or other similar formal relationship that is not treated as a marriage under applicable state law.

**State Children's Health Insurance Program (SCHIP)**

A state program for children's health insurance established under Title XXI of the Social Security Act of 1965 as amended.

**Written** or **Writing**

Written or Writing means a record which is on or transmitted by paper or electronic media which is acceptable to the Claims Administrator and consistent with applicable law.

**Year** or **Yearly**

For dental benefits, Yearly is defined as the 12-month period that begins January 1.

# APPENDIX A

**HIPAA PRIVACY PLAN AMENDMENT FOR**
**THE AVNET GROUP BENEFITS PLAN AND THE AVNET INSURED PLAN**

Avnet, Inc. ("Avnet") has adopted this Plan Document Amendment to the Avnet Group Benefits Plan and the Avnet Insured Plan, as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), to comply with 45 C.F.R. Parts 160 and 164 (the "HIPAA Privacy Rule"), and specifically 45 C.F.R. sec. 164.504(f), with respect to the portions or components of the Avnet Group Benefits Plan that provide or pay the cost of Medical Care.

## 1. Definitions

The following underscored terms, when appearing herein with an initial capital will have the meanings indicated for them in this Section 1.

"Covered Plan" or "Plan" means those portions or components of the Avnet Group Benefits Plan, which provide or pay the cost of Medical Care, including the:

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Puerto Rico Medical and Dental Plan*,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental, and
- Health Care Flexible Spending Account.

*As of February 27, 2017, the Puerto Rico Medical and Dental Plan is no longer a component of the Avnet Insured Plan.

"Plan" shall not include any portion or component of a plan that solely provides or pays the cost of Excepted Benefits.

"Designated Employees" means the following employees, classes of employees, and other persons who are designed to receive, use and disclose PHI on behalf of the Plan Sponsor:

(a) The individual employees designated in Exhibit A to this HIPAA Privacy Plan Amendment, to the extent they are designated therein to perform Plan Administration Functions on behalf of the Plan[1];

(b) Anyone under the immediate supervision of the individuals above;

(c) Individual employees or job categories approved by the above individuals to perform specific tasks on behalf of a Plan.

"Disclosed PHI" means PHI maintained by the Plan Sponsor, to the extent that such PHI is or has been disclosed to the Plan Sponsor by the Plan (or by an Insurer, if the Plan provides for or permits such disclosure to the Plan Sponsor), except that it does not include PHI released to the Plan Sponsor pursuant to Section 2 below.

"Enrollment Information" means information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the Plan.

[1]If the individuals identified in Exhibit A leaves the identified position they shall cease to be a Designated Employee and their replacement shall become a Designated Employee upon assuming the identified position.

"Excepted Benefits" means any one or more of the following:

(a) Coverage for accident, disability income insurance, or any combination thereof.

(b) Coverage issued as a supplement to liability insurance.

(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Worker's compensation or similar insurance.

(e) Automobile medical payment insurance.

(f) Credit-only insurance.

(g) Coverage for on-site medical clinics.

(h) Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

(i) Coverage for life insurance.

(j) Dependent care reimbursement account features of a Plan.

"Insurer" means either or both of:

(a) An insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, is subject to state laws that regulate insurance, and is providing coverage under the Plan.

(b) A federally-qualified health maintenance organization, an organization recognized as a health maintenance organization under applicable state law, or a similar organization regulated for solvency under applicable state law in the same manner and to the same extent as a health maintenance organization that is providing coverage under the Plan.

"Medical Care" means the diagnosis, cure, mitigation, treatment, or prevention of disease; services and supplies applied for the purpose of affecting any structure or function of the body; transportation primarily for and essential to obtaining any of the foregoing; and insurance covering any of the foregoing.

"Operations Functions" means any of the following activities when carried out with respect to the Payment Functions of the Plan:

(a) Quality assessment and improvement activities.

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management, disease management, care coordination, and contacting health care providers and enrollees with information about treatment alternatives and related functions.

(c) Rating provider and plan performance, including accreditation, certification, licensing, or credentialing activities.

(d) Fraud and abuse detection, and compliance activities.

(e) Underwriting, premium rating, and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance). Underwriting activities shall not include the use of PHI that is genetic information. For this purpose, "genetic information" includes information about an individual's genetic tests, the manifestation of disease or a disorder in their family members, and genetic counseling and genetic education they have received.

(f) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs.

(g) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, and development or improvement of payment methods or coverage policies.

(h) Business management and general administrative activities, including:

- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements.
- Customer service, including the preparation and provision of data analyses for use of the Plan Sponsor, policy holders, or other customers.

(i) Resolution of internal grievances.

(j) Due diligence in connection with the sale or transfer of assets to a potential successor in interest if the potential successor in interest either:

- Is a covered entity for purposes of HIPAA; or
- Will become a covered entity following completion of the sale or transfer.

(k) Subject to restrictions of the Privacy Rules, creating de-identified health information, summary health information, or limited data sets.

(l) Assisting other health plans, health care providers, and health care clearinghouses with their health care operations activities that are like those listed above in this definition, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with the individual whose PHI is involved and the PHI pertains to that relationship.

"Payment Functions" means activities undertaken to obtain premium payments or to determine or fulfill the Plan's responsibility for coverage of, and provision of health benefits with respect to, an individual to whom health care is provided. Payment functions include the following:

(a) Determining individuals' eligibility for coverage under the Plan, including determinations of rights pursuant to COBRA.

(b) Obtaining reimbursement for benefits paid during a period of ineligibility.

(c) Determining whether individuals have coverage in effect under the Plan, and in what capacity.

(d) Determining whether particular expenses are covered under the Plan with respect to individuals (including, without limitation, coordination of benefits determinations, cost sharing determinations, subrogation determinations, medical necessity determinations, and all other determinations necessary or appropriate to determine whether Plan benefits are payable for particular health benefit claims) and making claims payments based on those determinations.

(e) Coordination of benefits, including, without limitation, collecting amounts from another plan covering an individual, and determining order of benefits payment and the extent to which benefits have been paid from another plan.

(f) Activities related to rights of reimbursement the Plan may have with respect to previously-paid benefits, and subrogation activities, including asserting liens against actual or potential recoveries, exercising rights of reimbursement with respect to third parties, and making demand for repayment of Plan benefits.

(g) Determining cost-sharing amounts applicable to particular claims under the terms of the Plan, including determining whether an individual has reached applicable plan limits, satisfied Deductibles or out-of-pocket limits, or is required to make a co-payment or satisfy Coinsurance with respect to a particular claim.

(h) Adjudicating benefit claims under the Plan (including appeals and other payment disputes).

(i) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes, and responding to enrollees' inquiries about payments.

(j) Billing and collection activities, and related data processing.

(k) Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance), including notification to carriers issuing such insurance of diagnoses or claims that trigger reporting requirements under such policies.

(l) Review of health care services with respect to medical necessity, coverage under a health plan,

appropriateness of care, or justification of charges.

(m) Determining required employee contributions under the Plan.

(n) Risk adjusting amounts due for coverage based on enrollees' health status, claims history, and demographic characteristics, to the extent permissible under applicable law.

(o) Utilization review activities, including pre-certification and preauthorization of services, and concurrent and retrospective review of services.

(p) Disclosure to consumer reporting agencies relating to collection of premiums or reimbursement, limited to any or all of the following:

- Name and address
- Date of birth
- Social security number
- Payment history
- Account number
- Name and address of the Plan

(q) Assisting other health plans (including other health plans sponsored by the Plan Sponsor), health care providers, and health care clearinghouses with their payment activities, which include activities similar to those listed above in this definition with respect to the Plan.

"PHI" means protected health information, as defined in §160.103 of the Privacy Rules.

"Plan Administration Functions" means Payment Functions and Operations Functions.

"Plan Sponsor" means Avnet, Inc. and its related companies that sponsor one or more of the plans identified the definition of "Covered Plan" above, except that with respect to any particular Plan, "Plan Sponsor" means only the entity that sponsors that particular Plan.

"Privacy Rules" means the Standards for Privacy of Individually Identifiable Health Information promulgated by the Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, and found at 45 CFR part 160 and part 164, subparts A and E, as amended.

"Secretary" means the Secretary of the Department of Health and Human Services or his designee.

"Summary Health Information" means summary health information as defined in §164.504(a) of the Privacy Rules to the extent disclosed to the Plan Sponsor in accordance with §164.504(f)(1)(ii) of the Privacy Rules.

## 2. Use and Disclosure of Certain PHI by Plan Sponsor

Except as prohibited by § 164.502(a)(5)(i) of the Privacy Rules, a plan may disclose PHI to the Plan Sponsor: (i) if such information is Summary Health Information and is requested by the Plan Sponsor in order to obtain premium bids from health plans for providing health benefits under the Plan or to modify, amend, or terminate the plan; (ii) if such information is Enrollment Information; or (iii) if such information is disclosed pursuant to an authorization under 45 C.F.R. §164.508.

## 3. Use and Disclosure of PHI by Plan Sponsor with Limitations

With respect to any Disclosed PHI not described in Section 2 above, the Plan Sponsor may use and disclose such Disclosed PHI only as described in this Section 3.

(a) Plan Sponsor may use and disclose Disclosed PHI:

- For purposes of performing Plan Administration Functions on behalf of the Plan.
- As required by law, as that term is defined in §164.103 of the Privacy Rules.

(b) Plan Sponsor shall not use or disclose Disclosed PHI in a manner that the Plan would not be permitted to use and disclose the Disclosed PHI under the Privacy Rules.

(c) Plan Sponsor shall not use or further disclose the Disclosed PHI other than as permitted or required by the documents setting out the terms of the Plan or as required by law.

(d) Plan Sponsor shall require its agents, including subcontractors, to whom the Plan Sponsor provides Disclosed PHI, to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such Disclosed PHI.

(e) Plan Sponsor shall not use or disclose the Disclosed PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(f) Plan Sponsor shall report to the Plan any Security Incident (as that term is defined in 45 C.F.R. §164.403) or any use or disclosure of the Disclosed PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the documents setting out the terms of the Plan.

(g) Plan Sponsor will make the Disclosed PHI available to allow participants access to their PHI in accordance with §164.524 of the Privacy Rules.

(h) Plan Sponsor will make the Disclosed PHI available for amendment, and incorporate any amendments to such Disclosed PHI, in accordance with §164.526 of the Privacy Rules.

(i) Plan Sponsor will make available, in accordance with §164.528 of the Privacy Rules, the information required to provide an accounting of disclosures of the Disclosed PHI made by the Plan Sponsor, its agents or subcontractors.

(j) Plan Sponsor will make its internal practices, books, and records relating to the use and disclosure of the Disclosed PHI available to the Secretary for purposes of determining compliance by the Plan with the Privacy Rules.

(k) If feasible, the Plan Sponsor will return to the Plan, or destroy, all Disclosed PHI maintained by the Plan Sponsor in any form, and retain no copies, when such Disclosed PHI is no longer needed for the purpose for which disclosure of it was made to the Plan Sponsor, except that, if such return or destruction is not feasible, the Plan Sponsor shall instead limit further uses and disclosures of the information by the Plan Sponsor, its agents and subcontractors to uses and disclosures required by law and those made for the purposes that make return or destruction of the Disclosed PHI infeasible.

## 4. Disclosure of PHI to Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor solely through the Designated Employees, and only for the purposes specified in Section 3(a) hereof.

## 5. Adequate Separation

(a) No one who is an employee, or is otherwise under the control, of the Plan Sponsor, other than the Designated Employees, may have access to the Disclosed PHI.

(b) The Plan Sponsor shall implement appropriate administrative, physical and technical safeguards to prohibit its employees and other persons under its control, other than the Designated Employees, from accessing the Disclosed PHI.

(c) The Designated Employees may have access to and use the Disclosed PHI only for the purposes specified in Section 3(a) hereof.

(d) The Plan Sponsor shall implement appropriate administrative, physical, and technical safeguards to prohibit and/or prevent Designated Employees from accessing the Disclosed PHI for purposes other than those specified in Section 3(a) hereof.

(e) Any employee who intentionally accesses, uses or discloses Disclosed PHI for any purpose not specified in Section 3(a) hereof, and any Designated Employee who acts with respect to the Disclosed PHI in a manner contrary to the provisions of this Section 5 will be subject to disciplinary action at the Plan Sponsor's discretion, which may include termination of employment.

This Addendum supersedes any inconsistent provisions in the documents governing the Plans and replaces any prior amendments or addenda dealing with the subject matter hereof.

**Exhibit A**

**Avnet Group Benefits Plan and Avnet Insured Plan Components**

**and**

**Designated Avnet Employees**

(Revised January 1, 2019)

The portions or components of the Plan that provide or pay the cost of healthcare, include:

- HSA 70 Medical Plan,
- HSA 80 Medical Plan,
- Classic 70 Medical Plan,
- Out-of-Area Medical Plan,
- Kaiser Permanente Medical Plan,
- Hawaii Medical Plan,
- Puerto Rico Medical and Dental Plan*,
- Employee Assistance Program/Behavioral Health,
- Vision Service Plan,
- PPO Dental,
- Copay Dental, and
- Health Care Flexible Spending Account.

*As of February 27, 2017, the Puerto Rico Medical and Dental Plan is no longer a component of the Avnet Insured Plan.

The following employees, classes of employees, and other persons are hereby designated to perform Plan Administration Functions on behalf of the Avnet Group Benefits Plan and Avnet Insured Plan:

| **Designated Employees (Job Title)** | **Current Incumbent*** |
|---|---|
| Director, Global Benefits | Anna Conti |
| Senior Benefits Consultant | Andrea Sherry |
| Rewards Advisor | Karen Hamacher |
| Rewards Advisor | Beth Crothers |
| Rewards Avdisor | Alisandra Deanda |

***The current incumbent is listed as of the date this Exhibit was last revised. If the incumbent subsequently changes, the new employee in the designated position will be automatically designated hereunder.*

***End of Summary Plan Description