Summary Plan Description

American Air Liquide Holdings
Dental

Effective: January 1, 2013
Group Number: 704366

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SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries;
- Claims submittal address: Dental Claims, P.O. Box 30567, Salt Lake City, UT 84130-0567; and
- Online assistance: **www.myuhcdental.com**.

This Summary Plan Description describes the terms and conditions of Coverage under American Air Liquide Holdings Welfare Benefit Plan ("Plan"). Read this document carefully so that you will have a clear understanding of your Coverage under the Plan. If you have any questions regarding your Coverage or procedures for obtaining Dental Services, you may call the toll-free number shown on your ID card or contact the Plan Administrator. American Air Liquide Holdings is utilizing the services of United HealthCare Services, Inc. the administration of Coverage under the Plan.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Plan. As a Summary Plan Description ("SPD"), this document describes the provisions of Coverage under the Plan but does not constitute the entire Plan. You may examine the entire Plan at the office of the Plan Sponsor during regular business hours.

For Dental Services rendered after the effective date of the Plan, this SPD replaces and supersedes any SPD which may have been previously issued to you by the Plan Sponsor. Any subsequent SPDs issued to you by the Plan Sponsor will in turn supersede this SPD.

How To Use This SPD

This SPD should be read and re-read in its entirety. Many of the provisions of this SPD are interrelated; therefore, reading just one or two provisions may not give you an accurate understanding of your Coverage.

Your SPD may be modified by the attachment of Amendments. Please read the provision described in these documents to determine the way in which provisions in this SPD may have been changed.

Many words used in this SPD have special meanings. These words will appear capitalized and are defined for you in Section 11, *Glossary*. By reviewing these definitions, you will have a clearer understanding of your SPD.

From time to time, the Plan may be amended. When that happens, a new SPD or Amendment pages for this SPD will be sent to you. Your SPD should be kept in a safe place for your future reference.

Network and Non-Network Benefits

This SPD describes both Network and Non-Network benefit levels available under the Plan.

Network Benefits - These benefits apply when you choose to obtain Dental Services from a Network Dentist. Section 3, *How the Plan Works* describes the procedures for obtaining Covered Dental Services as Network Benefits. Unless otherwise noted in Section 4, *Plan Highlights*, Network Benefits generally provide Coverage at a higher level than Non-Network Benefits.

Non-Network Benefits - These benefits apply when you decide to obtain Dental Services from Non-Network Dentists. Section 3, *How the Plan Works* describes the procedures for obtaining Coverage of Dental Services as Non-Network Benefits. Unless otherwise noted in Section 4, *Plan Highlights*, Non-Network Benefits are subject to an Annual Deductible and are generally Covered at a lower level than Network Benefits. In addition, when you obtain Dental Services from Non-Network Dentists, you must file a claim to be reimbursed for Eligible Expenses. For information on the Plan's reimbursement policy guidelines used to determine Eligible Expenses, you should contact United HealthCare Services, Inc. at the telephone number on your ID card.

Dental Services Covered Under the Plan

In order for Dental Services to be Covered as Network Benefits, you must obtain all Dental Services directly from or through a Network Dentist.

You should always verify the participation status of a Dentist prior to seeking services. From time to time, the participation status of a Dentist may change. You can verify the participation status by calling United HealthCare Services, Inc. If necessary, United HealthCare Services, Inc. can provide assistance in referring you to Network Dentists. If you use a Dentist that is not a participating Dentist, you will be required to pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.

Only Necessary Dental Services are Covered under the Plan. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Plan.

Important Information Regarding Medicare

Coverage under the Plan is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Plan. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare and do not enroll for and maintain coverage under both Medicare Part A and Part B and if the Plan Sponsor is the secondary payer as described in the Section 9, *Coordination of Benefits*, the Plan Sponsor will pay benefits under the Plan as if you were covered under both Medicare Part A and Part B and you will incur a larger out of pocket cost for Dental Services.

If, in addition to being enrolled for Coverage under the Plan, you are enrolled in a Medicare Advantage (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating Dentists. When the Plan Sponsor is the secondary payer, the Plan will pay any benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. If this Plan is the secondary plan and you don't follow the rules of the Medicare Advantage plan, you will incur a larger out of pocket cost for Dental Services.

Identification ("ID") Card

You must show your ID card every time you request Dental Services. If you do not show your card, the Dentists have no way of knowing that you are Covered under a Plan issued by the Plan Sponsor.

Contact the Plan Administrator

Whenever you have a question or concern regarding Dental Services or any required procedure, please contact the Plan Administrator or call the telephone number stated on your ID card.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Participant who is scheduled to work at least 30 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 11, *Glossary*;
- your same-sex domestic partner;
- your, your same-sex domestic partner's or your Spouse's unmarried child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian;
- an unmarried child of any age who is or becomes disabled and dependent upon you; or
- your unmarried child age 26 but under age who is:
  - a Full-time Student, as defined in Section 11, *Glossary*;
  - not regularly employed on a full-time basis; and
  - primarily dependent on you for support and maintenance.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the American Air Liquide Holdings Health Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 10, *Other Important Information*.

Cost of Coverage

You and American Air Liquide Holdings share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Your contributions are subject to review and American Air Liquide Holdings reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for dental Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your dental election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.).

The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- you or your eligible Dependent incurs a claim that would exceed a lifetime limit on all benefits under the elected health care option through American Air Liquide Holdings;
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

If you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all dental Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses
- Annual Deductible;
- Annual Maximum Benefit;
- Lifetime Maximum Benefit;
- Lifetime Maximum Benefit for Orthodontic Services; and
- Coinsurance.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Dentist you prefer each time you need to receive Covered Dental Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Dental Services from Dentists who have contracted to provide those services.

Generally, when you receive Covered Dental Services from a Network Dentist, you pay less than you would if you receive the same care from a non-Network Dentist. Your level of Benefits will be the same if you visit a Network Dentist or non-Network Dentist. Because the total amount of Eligible Expenses may be less when you use a Network Dentist, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network Dentist.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network Dentist about their billed charges before you receive care. Emergency services received at a non-Network Dentist are covered at the Network level.

Looking for a Network Dentist?
In addition to other helpful information, **www.myuhcdental.com** contains a directory of Network health care professionals and facilities. While Network status may change from time to time, **www.myuhcdental.com** has the most current source of Network information. Use **www.myuhcdental.com** to search for Dentists available under your Plan.

Network Dentists

You may request a directory of Network Dentists free of charge. Keep in mind, a Dentist's Network status may change at any time. To verify a Dentist's current status or request a Dentist directory, you can call the toll-free number on your ID card or log onto **www.myuhcdental.com**.

Network Dentists are independent practitioners and are not employees of the Plan or the Claims Administrator.

Eligible Expenses

Eligible Expenses are charges for Covered Dental Services that are provided while the Plan is in effect, determined according to the definition in Section 11, *Glossary*. For certain Covered Dental Services, the Plan will not pay these expenses until you have met your Annual Deductible. American Air Liquide Holdings has delegated to United HealthCare Services, Inc. the initial discretion and authority to decide whether a treatment or supply is a Covered Dental Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card
Remember to show your ID card every time you receive dental services from a Dentist. If you do not show your ID card, a Dentist has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Dental Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Annual Maximum Benefit

The Annual Maximum Benefit is the maximum amount the Plan will pay each calendar year for Covered Dental Services. There are separate Network and non-Network Annual Maximum Benefits for this Plan.

Lifetime Maximum Benefit for Orthodontic Services

The Lifetime Maximum Benefit is the most the Plan will pay for orthodontic services during the entire period you are enrolled in this Plan and any other dental plans offered by American Air Liquide Holdings. There is a combined Network and non-Network Lifetime Maximum Benefit for this Plan.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Dental Services after you meet the Annual Deductible.

SECTION 4 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible, Annual Maximum Benefit and Lifetime Maximum Benefits.

Plan Features	Network	Non-Network
Annual Deductible		
■ Individual	$50	$50
■ Family	$100	$100
Annual Maximum Benefit	$1,500 per Covered Person, per calendar year	
Lifetime Maximum Benefit for Orthodontic Services	$1,000 per Covered Person, per lifetime	
Benefit Description & Limitation	**Percentage of Eligible Expenses Payable by the Plan:**	
	Network	**Non-Network***
*You must also pay the amount of the Dentist's fee, if any, which is greater than the Eligible Expense.		
DIAGNOSTIC SERVICES		
Bacteriologic Cultures	100%	100%
Viral Cultures	100%	100%
Bite-Wing Radiographs Limited to 1 series of films per calendar year. Intraoral Bitewing Radiographs	100%	100%
Complete Series or Panorex Radiographs Limited to one time per 36 months.	100%	100%
Oral/Facial Photographic Images Limited to 1 time per consecutive 36 months.	100%	100%

Plan Features	Network	Non-Network
Diagnostic Casts Limited to one time per 24 months.	100%	100%
Extraoral Radiographs Limited to 2 films per calendar year.	100%	100%
Intraoral - Complete Series (including bitewings) Limited to 1 time per consecutive 36 months. Vertical bitewings can not be billed in conjunction with a complete series.	100%	100%
Individual Periapical Radiographs Intraoral Periapical Radiographs	100%	100%
Pulp Vitality Tests Limited to 1 charge per visit, regardless of how many teeth are tested.	100%	100%
Intraoral Occlusal Film	100%	100%
Periodic Oral Evaluation Limited to 2 times per calendar year.	100%	100%
Comprehensive Oral Evaluation Limited to 2 times per calendar year. Not Covered if done in conjunction with other exams.	100%	100%
Limited or Detailed Oral Evaluation Only 1 exam is Covered per date of service.	100%	100%
Comprehensive Periodontal Evaluation - new or established patient Limited to 2 times per calendar year.	100%	100%

Plan Features	Network	Non-Network
Adjunctive Pre-Diagnostic Test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures Limited to 1 time per consecutive 12 months.	100%	100%
PREVENTIVE SERVICES		
Dental Prophylaxis Cleanings Limited to two times per calendar year.	100%	100%
Fluoride Treatments Fluoride Treatments - child Limited to Covered Persons under the age of 19 years, and limited to 2 times per calendar year.	100%	100%
Sealants Limited to Covered Persons under the age of 14 years and once per first or second permanent molar every 3 calendar years.	100%	100%
Space Maintainers Limited to Covered Persons under the age of 16 years, once per lifetime. Benefit includes all adjustments within 6 months of installation.	100%	100%
Re-Cement Space Maintainers	100%	100%

Plan Features	Network	Non-Network
MINOR RESTORATIVE SERVICES		
Amalgam Restorations Fillings Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Composite Resin Restorations Fillings Composite Resin Restorations - Anterior Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
ENDODONTICS		
Apexification	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Apicoectomy and Retrograde filling	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Hemisection	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Root Canal Therapy Limited to 1 time per tooth per lifetime. Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
Root Resection/Amputation	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Therapeutic Pulpotomy	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Covered for anterior or posterior teeth only.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulp Caps - Direct/Indirect – excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Pulpal Debridement, Primary and Permanent Teeth This procedure is not to be used when endodontic services are done on same date of service.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
PERIODONTICS		
Crown Lengthening	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingivectomy/Gingivoplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Gingival Flap Procedure	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Osseous Graft	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
Osseous Surgery	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Guided Tissue Regeneration	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Soft Tissue Surgery	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Periodontal Maintenance Following active or adjunctive periodontal therapy, exclusive of gross debridement.	100%	100%
Full Mouth Debridement	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory based crowns or bridges for the purposes of provisional splinting.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Scaling and Root Planning	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to 3 sites per quadrant, or 12 sites total, for refractory pockets, or in	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
conjunction with scaling or root planning, by report.		
ORAL SURGERY		
Alveoloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Biopsy	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Frenectomy/Frenuloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Incision and Drainage	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of a Benign Cyst/Lesions	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Removal of Torus	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Root Removal	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Simple Extraction Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Erupted Teeth or Roots Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Surgical Extraction of Impacted Teeth Limited to 1 time per tooth per lifetime.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Primary Closure of a Sinus Perforation	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Placement of Device to Facilitate Eruption of Impacted Tooth	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Vestibuloplasty	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Bone Replacement Graft for Ridge Preservation - per site Not Covered if done in conjunction with other bone graft replacement procedures.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Excision of Hyperplastic Tissue or Pericoronal Gingiva	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Tooth Reimplantation and/or Transplantation Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Oroantral Fistula Closure	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
ADJUNCTIVE SERVICES		
Analgesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Desensitizing Medicament	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
General Anesthesia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Local Anesthesia Not Covered in conjunction with operative or surgical procedure.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Intravenous Sedation and Analegsia Covered when Necessary in conjunction with Covered Dental Services. If required for patients under 6 years of age or patients with behavioral problems or physical disabilities or if it is clinically Necessary. Covered for patients over age of 6 if it is clinically Necessary.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
Occlusal Adjustment	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guards Limited to 1 guard every consecutive 60 months and only covered if prescribed to control habitual grinding.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusal Guard Reline and Repair Limited to relining and repair performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Occlusion Analysis - Mounted Case Limited to 1 time per consecutive 60 months.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Palliative Treatment Covered as a separate benefit only if no other services, other than exam and radiographs, were done on the same tooth during the visit.	100%	100%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not Covered if done with exams or professional visit.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Plan Features	Network	Non-Network
MAJOR RESTORATIVE SERVICES		
Coping Not Covered if done at the same time as a crown on same tooth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Crowns – Retainers/Abutments Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Crowns - Restorations Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Temporary Crowns - Restorations Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays – Retainers/Abutments Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Inlays/Onlays - Restorations Covered only when a filling cannot restore the tooth. Not Covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Plan Features	Network	Non-Network
Pontics Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to 1 time per tooth per consecutive 60 months.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Pin Retention Limited to 2 pins per tooth; not covered in addition to cast restoration.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Post and Cores Covered only for teeth that have had root canal therapy.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Re-cement Bridges Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to those performed more than 12 months after the initial insertion.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Sedative Filling Covered as a separate benefit only if no other service, other than x-rays and exam, were done on the same tooth during the visit.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Stainless Steel Crowns Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Plan Features	Network	Non-Network
FIXED PROSTHETICS		
Fixed Partial Dentures (Bridges)	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
REMOVABLE PROSTHETICS		
Complete Dentures No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Partial Dentures No additional allowances for precision or semi-precision attachments.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Relining Dentures and Rebasing Dentures Limited to relining/rebasing performed more than 6 months after the initial insertion.	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Tissue Conditioning - Maxillary or Mandibular	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Repairs to Full Dentures, Partial Dentures, Bridges Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns. Limited to repairs or adjustments performed more than 12 months after the initial insertion..	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Plan Features	Network	Non-Network
ORTHODONTICS		
Orthodontic Services Services or supplies furnished by a Dentist to a Dependent in order to diagnose or correct misalignment of the teeth or the bite. The extended coverage provision does not apply to orthodontic services.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Appliance Therapy, Fixed or Removable Limited to 1 time per consecutive 60 months. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Cephalometric Film Can only be billed for orthodontics.	50% after you meet the Annual Deductible	50% after you meet the Annual Deductible

SECTION 5 - EXCLUSIONS: WHAT THE DENTAL PLAN WILL NOT COVER

Except as may be specifically provided in the Section entitled *Plan Highlights* through a rider to the Plan or through an Amendment to the SPD, the following are not Covered:

1. Dental Services that are not Necessary.

2. Hospitalization or other facility charges.

3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

4. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

5. Any Dental Procedure not directly associated with dental disease.

6. Any Dental Procedure not performed in a dental setting.

7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

8. Placement of dental implants, implant-supported abutments and prostheses.

9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.

13. Replacement of complete dentures, and fixed and removable partial dentures or crowns, if damage or breakage was directly related to Dental error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

15. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

16. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

19. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

22. Services rendered by a Dentist with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

23. Dental Services otherwise Covered under the Plan, but rendered after the date individual Coverage under the Plan terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Plan terminates, except those conditions Covered under the Extension of Benefits in Section 3.

24. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

25. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.

26. In the event that a non-Network Dentist routinely waives Coinsurance and/or the Deductible for a particular Dental Service, the Dental Service for which the Coinsurance

and/or Deductible are waived is reduced by the amount waived by the non-Network Dentist.

27. Foreign Services are not Covered unless required as an Emergency.

28. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

29. Any Dental Services or Procedures not listed in Section 4, *Plan Highlights*.

SECTION 6 - CLAIMS PROCEDURES

What this section includes:
- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Dental Services from a Network Dentist, the Dentist will be paid directly. If a Network Dentist bills you for any Covered Health Service other than your Coinsurance, please contact the Dentist or call the phone number on your ID card for assistance.

Keep in mind, you are responsible for paying any Coinsurance owed to a Network Dentist at the time of service, or when you receive a bill from the Dentist.

Non-Network Benefits

If you receive a bill for Covered Dental Services from a non-Network Dentist, you (or the Dentist if they prefer) must submit the bill for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the address on the back of your ID card.

If Your Dentist Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhcdental.com**, calling the toll-free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the Dentist of the service(s);
- a diagnosis from the Dentist;
- the date of service;
- an itemized bill from the Dentist that includes:
  - the American Dental Association (ADA) codes;
  - a description of, and the charge for, each service;
  - the date the sickness or injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

After your claim has been processed, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network Dentist the charges you incurred, including any difference between what you were billed and what the Plan paid.

Non-Network Benefits will be paid to you unless:

- the Dentist provides notice that you have signed an authorization to assign Benefits directly to that Dentist; or
- you make a written request for the non-Network Dentist to be paid directly at the time you submit your claim.

Benefits will only be paid to you or, with written authorization by you, to your Dentist, and not to a third party, even if your Dentist has assigned Benefits to that third party.

Explanation of Benefits (EOB)

You may receive an Explanation of Benefits (EOB) after your claim is processed. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. You can also view and print all of your EOBs online at **www.myuhcdental.com**. See Section 11, *Glossary* for the definition of Explanation of Benefits.

Important
All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call United HealthCare Services, Inc. at the number on your ID card before requesting a formal appeal. If United HealthCare Services, Inc. cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If a claim for Benefits is denied in part or in whole, you may call the number on your ID card before requesting a formal appeal. If the issue cannot be resolved to your satisfaction over the phone, you have the right to file a formal appeal as described below.

- the patient's name and ID number as shown on the ID card;
- the Dentist's name;
- the date of dental service;

- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your enrolled Dependent may send a written request for an appeal to:

Dental-Appeals
P.O. Box 30569
Salt Lake City, UT 84130-0569

Review of an Appeal

A full and fair review of your appeal will be conducted. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if the denial is upheld, you will receive a written explanation of the reasons and facts relating to the denial.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care;
- pre-service; or
- post-service claim.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care - a claim for Benefits provided in connection with Emergency services;
- Pre-Service - a claim for Benefits filed before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and the Claims Administrator are required to follow.

Urgent Care Claims*	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, you must be notified within	**24 hours**
You must then provide completed claim information to United HealthCare Services, Inc. within:	**48 hours** after receiving notice
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**72 hours**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
You must be notified of the appeal decision within:	**72 hours** after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call United HealthCare Services, Inc. as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is filed improperly, you must be notified within:	**5 days**
If your claim is incomplete, you must be notified within:	**15 days**
You must then provide completed claim information within:	**45 days** after receiving an extension notice*
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**15 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**15 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial

Pre-Service Claims	
Type of Claim or Appeal	**Timing**
You must be notified of the first level appeal decision within:	**15 days** after receiving the first level appeal

*A one-time extension of no more than 15 days may be required only if more time is needed due to uncontrollable circumstances.

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, you must be notified within:	**30 days**
You must then provide completed claim information to United HealthCare Services, Inc. within:	**45 days** after receiving an extension notice*
If your initial claim is denied, you must be notified of the denial:	
■ if the initial claim is complete, within:	**30 days**
■ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
You must be notified of the first level appeal decision within:	**30 days** after receiving the first level appeal

* A one-time extension of no more than 15 days may be required only if more time is needed due to uncontrollable circumstances.

Limitation of Action

You cannot bring any legal action against American Air Liquide Holdings or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against American Air Liquide Holdings or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against American Air Liquide Holdings or the Claims Administrator.

You cannot bring any legal action against American Air Liquide Holdings or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against American Air Liquide Holdings or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against American Air Liquide Holdings or the Claims Administrator.

SECTION 7 - SUBROGATION AND REIMBURSEMENT

What this section includes:
- How your Benefits are impacted if you suffer a sickness or injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

The Plan 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; or
- 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 will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible, 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; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the sickness or injury for which a third party is considered responsible. Subrogation applies when the Plan has paid on your behalf Benefits for a sickness or injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the sickness, injury or damages;
- any insurer or other indemnifier of any person or entity who caused the sickness, injury or damages;
- American Air Liquide Holdings in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
  - underinsured or uninsured motorist insurance;
  - dental provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
  - workers' compensation coverage; or
  - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party.
- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to,

economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - complying with the terms of this section;
  - providing any relevant information requested;
  - signing and/or delivering documents at its request;
  - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - responding to requests for information about any accident or injuries;
  - appearing at dental examinations and legal proceedings, such as depositions or hearings; and
  - obtaining the Plan's consent before releasing any party from liability or payment of dental expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a sickness or injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you.
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a sickness or injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the

Plan has paid relating to any sickness or injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.

- if a third party causes you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

SECTION 8 - WHEN COVERAGE ENDS

What this section includes:
- Circumstances that cause coverage to end; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are receiving dental treatment on that date.

When your coverage ends, American Air Liquide Holdings will still pay claims for Covered Dental Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for dental services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month United HealthCare Services, Inc. receives written notice from American Air Liquide Holdings to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month United HealthCare Services, Inc. receives written notice from American Air Liquide Holdings to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

The Plan will provide written notice to you that your coverage has ended if any of the following occur:

- you permit an unauthorized person to use your ID card or you use another person's ID card;

- you knowingly give United HealthCare Services, Inc. false material information including, but not limited to, false information relating to another person's eligibility or status as a Dependent;
- you commit an act of physical or verbal abuse that imposes a threat to American Air Liquide Holdings' staff, United HealthCare Services, Inc.'s staff, a Dentist or another Covered Person; or
- you violate any terms of the Plan.

Note: American Air Liquide Holdings has the right to demand that you pay back Benefits American Air Liquide Holdings paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Extended Coverage

A 30 day temporary extension of Coverage, only for the services shown below when given in connection with a Procedure in Progress, will be granted to a Covered Person on the date the person's Coverage is terminated if termination is not voluntary. Benefits will be extended until the earlier of: (a.) the end of the 30 day period; or (b.) the date the Covered Person becomes covered under a succeeding policy or contract providing coverage or services for similar dental procedures.

Benefits will be Covered for: (a.) a Procedure in Progress or Dental Procedure that was recommended in writing and began, in connection with a specific dental disease of a Covered Person while the Plan was in effect, by the attending Dentist; (b.) an appliance, or modification to an appliance, for which the impression was taken prior to the termination of Coverage; or (c.) a crown, bridge or gold restoration, for which the tooth was prepared prior to the termination of Coverage.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to American Air Liquide Holdings proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon American Air Liquide Holdings' request, that the child continues to meet these conditions.

The proof might include dental examinations at the Plan's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 11, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if COBRA benefits are available to you.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
American Air Liquide Holdings files for bankruptcy under Title 11, United States Code.[2]	36 months	36 months[3]	36 months[3]

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

[2]This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

[3]From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

*Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Dentist, inform that Dentist of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the dental Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 12, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group dental plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required

to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 9 - COORDINATION OF BENEFITS

What this section includes:

- How your Benefits under this Plan coordinate with other plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits Applicability

This coordination of benefits (COB) provision applies when a person has health or dental coverage under more than one Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Definitions

For purposes of this Section, Coordination of Benefits, terms are defined as follows:

- A "Coverage Plan" is any of the following that provides benefits or services for dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
  - "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); dental benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
  - "Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-dental components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

  Each contract for coverage under either definition of "Plan" is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.
- The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

  When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When

this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

- "Allowable expense" means a health care service or expense, including deductibles and coinsurance, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example a dental HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
  - If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of Usual and Customary fees, any amount in excess of the highest of the Usual and Customary fees for a specific benefit is not an allowable expense.
  - If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
  - If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of Usual and Customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the primary Coverage Plan's payment arrangements will be the allowable expense for all Coverage Plans.
- "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.
- "Closed panel Coverage Plan" is a Coverage Plan that provides health or dental benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

- The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.
- A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage will be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major dental coverages that are superimposed over base Coverage

Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

- A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.
- The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.
  - **Non-Dependent or Dependent**. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, Subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, Subscriber or retiree is secondary and the other Coverage Plan is primary.
  - **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one Coverage Plan is:
    - The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
      - the parents are married;
      - the parents are not separated (whether or not they ever have been married); or
      - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
    - If the specific terms of a court decree state that one of the parents is responsible for the child's health or dental care expenses or health or dental care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or Coverage Plan years commencing after the Coverage Plan is given notice of the court decree.
    - If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
      - the Coverage Plan of the custodial parent;
      - the Coverage Plan of the spouse of the custodial parent;
      - the Coverage Plan of the noncustodial parent; and then
      - the Coverage Plan of the spouse of the noncustodial parent.
  - **Active or inactive employee**. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans

do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule for "Non-Dependent or Dependent"

- **Continuation coverage**. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, Subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
- **Longer or shorter length of coverage**. The Coverage Plan that covered the person as an employee, member, Subscriber or retiree longer is primary.
- If the preceding rules do not determine the primary Coverage Plan, the allowable expenses will be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of This Coverage Plan

When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When this Coverage Plan is the secondary carrier, this Coverage Plan will only pay the difference between what this Coverage Plan would have paid as primary minus what the other carrier paid.

- If a covered person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB will not apply between that Coverage Plan and other closed panel Coverage Plans.
- This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

  Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

  - The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
  - The person is enrolled in a Medicare Advantage (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
  - The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
  - The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.

- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health or dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. The Company may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming benefits.

The Company does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give the Claims Administrator any facts it needs to apply those rules and determine benefit payable. If you do not provide the Claims Administrator the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, the Claims Administrator (on behalf of the Plan Administrator) may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Claims Administrator (on behalf of the Plan Administrator) is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it had paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION 10 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with the Plan and the Claims Administrator;
- Relationships with Dentists;
- Interpretation of Benefits;
- Information and records;
- Incentives to Dentists and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

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 dental benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a dental 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, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

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

Your Relationship with United HealthCare Services, Inc. and American Air Liquide Holdings

In order to make choices about your dental coverage and treatment, American Air Liquide Holdings believes that it is important for you to understand how United HealthCare Services, Inc. interacts with the Plan Sponsor's benefit Plan and how it may affect you. United HealthCare Services, Inc. helps administer the Plan Sponsor's benefit plan in which you are enrolled. United HealthCare Services, Inc. does not provide dental services or make treatment decisions. This means:

- American Air Liquide Holdings and United HealthCare Services, Inc. do not decide what care you need or will receive. You and your Dentist make those decisions;

- United HealthCare Services, Inc. communicates to you decisions about whether the Plan will cover or pay for the Dental Services that you may receive (the Plan pays for Covered Dental Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Dentist may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

American Air Liquide Holdings and United HealthCare Services, Inc. may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. American Air Liquide Holdings and United HealthCare Services, Inc. will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. American Air Liquide Holdings and United HealthCare Services, Inc. will use de-identified data for commercial purposes including research.

Relationship with Dentists

The relationships between American Air Liquide Holdings, United HealthCare Services, Inc. and Network Dentists are solely contractual relationships between independent contractors. Network Dentists are not American Air Liquide Holdings' agents or employees, nor are they agents or employees of United HealthCare Services, Inc. American Air Liquide Holdings and any of its employees are not agents or employees of Network Dentists, nor are United HealthCare Services, Inc. and any of its employees agents or employees of Network Dentists.

American Air Liquide Holdings and United HealthCare Services, Inc. do not provide dental services or supplies, nor do they practice dentistry. Instead, American Air Liquide Holdings and United HealthCare Services, Inc. arranges for Dentists to participate in a Network and pay Benefits. Network Dentists are independent practitioners who run their own offices and facilities. United HealthCare Services, Inc.'s credentialing process confirms public information about the Dentists' licenses and other credentials, but does not assure the quality of the services provided. They are not American Air Liquide Holdings' employees nor are they employees of United HealthCare Services, Inc. American Air Liquide Holdings and United HealthCare Services, Inc. do not have any other relationship with Network Dentists such as principal-agent or joint venture. American Air Liquide Holdings and United HealthCare Services, Inc. are not liable for any act or omission of any Dentist.

United HealthCare Services, Inc. is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

American Air Liquide Holdings and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Dentists

The relationship between you and any Dentist is that of Dentist and patient. Your Dentist is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own Dentist;
- are responsible for paying, directly to your Dentist, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your Dentist, the cost of any non-Covered Dental Service;
- must decide if any Dentist treating you is right for you (this includes Network Dentists you choose and Dentists to whom you have been referred); and
- must decide with your Dentist what care you should receive.

Interpretation of Benefits

American Air Liquide Holdings and United HealthCare Services, Inc. have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

American Air Liquide Holdings and United HealthCare Services, Inc. may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, American Air Liquide Holdings may, in its discretion, offer Benefits for services that would otherwise not be Covered Dental Services. The fact that American Air Liquide Holdings does so in any particular case shall not in any way be deemed to require American Air Liquide Holdings to do so in other similar cases.

Information and Records

American Air Liquide Holdings and United HealthCare Services, Inc. may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. American Air Liquide Holdings and United HealthCare Services, Inc. may request additional information from you to decide your claim for Benefits. American Air Liquide Holdings and United HealthCare Services, Inc. will keep this information confidential. American Air Liquide Holdings and United HealthCare Services, Inc. may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish American Air Liquide Holdings and United HealthCare Services, Inc. with all information or copies of records relating to the services provided to you. American Air Liquide Holdings and United HealthCare Services, Inc. have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Participant's enrollment form. American Air Liquide Holdings and United HealthCare Services, Inc. agree that such information and records will be considered confidential.

American Air Liquide Holdings and United HealthCare Services, Inc. have the right to release any and all records concerning dental services which are necessary to implement and administer the terms of the Plan, for appropriate dental review or quality assessment, or as American Air Liquide Holdings is required to do by law or regulation. During and after the term of the Plan, American Air Liquide Holdings and United HealthCare Services, Inc. and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your records or billing statements American Air Liquide Holdings recommends that you contact your Dentist. Dentists may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request dental forms or records from United HealthCare Services, Inc., they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, American Air Liquide Holdings and United HealthCare Services, Inc. will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

Incentives to Dentists

Network Dentists may be provided financial incentives by United HealthCare Services, Inc. to promote the delivery of dental care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to dental care.

Examples of financial incentives for Network Dentists are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network Dentists receives a monthly payment from United HealthCare Services, Inc. for each Covered Person who selects a Network Dentist within the group to perform or coordinate certain dental services. The Network Dentists receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's dental care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network Dentist is paid by any

financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Dentist.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but American Air Liquide Holdings recommends that you discuss participating in such programs with your Dentist. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 11 - GLOSSARY

This Section defines the terms used throughout this SPD and is not intended to describe Covered or uncovered services.

Amendment – any attached description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan except for those which are specifically amended.

Annual Deductible – the amount a Covered Person must pay for Dental Services in a calendar year before the Plan will begin paying for Network and Non-Network Benefits in that calendar year.

Annual Maximum Benefit – the maximum amount paid for Covered Dental Services during a calendar year for a Covered Person under any Plan offered by American Air Liquide Holdings. The Maximum Benefit is stated in Section 4, *Plan Highlights*.

Claims Administrator – United HealthCare Services, Inc. (also known as Dental Benefit Providers, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Dental Services as described in Section 3, *How the Plan Works*.

Company – American Air Liquide Holdings.

Congenital Anomaly – a physical developmental defect that is present at birth and identified within the first twelve months from birth.

Coverage or **Covered** – the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Plan, subject to the terms, conditions, limitations and exclusions of the Plan. Dental Services must be provided: (1) when the Plan is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Plan.

Covered Person – either the Participant or an Enrolled Dependent while Coverage of such person under the Plan is in effect. References to "you" and "your" throughout this SPD are references to a Covered Person.

Deductible – see Annual Deductible.

Dental Service or Dental Procedures – dental care or treatment provided by a Dentist to a Covered Person while the Plan is in effect, provided such care or treatment is recognized by the Plan Administrator as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentist – any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Eligible Expenses – Eligible Expenses for Covered Dental Services, incurred while the Plan is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dentists, Eligible Expenses are United HealthCare Services, Inc.'s contracted fee(s) for the Dental Service with that Dentist.
- For Non-Network Benefits, when Covered Dental Services are received from non-Network Dentist, Eligible Expenses are the Usual and Customary fees as defined below.

Eligible Expenses must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for Benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Emergency – a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Enrolled Dependent – a Dependent who is properly enrolled for Coverage under the Plan.

Experimental, Investigational or Unproven Services – medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time United HealthCare Services, Inc. makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- subject to review and approval by any institutional review board for the proposed use; or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Foreign Services – are defined as services provided outside the U.S. and U.S. territories.

Full-time Student – a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- an accredited high school;
- an accredited college or university; or
- a licensed vocational school, technical school, beautician school, automotive school or similar training school.

The educational institution determines what constitutes Full-time Student status. You are no longer a Full-time Student as of the last day of the calendar month you graduate, do not return as a Full-time Student immediately following vacation or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

Lifetime Maximum Benefit for Orthodontic Services – the maximum amount paid for orthodontic services during the entire period of time that the Covered Person is Covered under the Plan or any Plan, offered by American Air Liquide Holdings. The Lifetime Maximum Benefit for Orthodontic Services is stated in Section 4, *Plan Highlights*.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Necessary – Dental Services and supplies which are determined to be appropriate, and

- necessary to meet the basic dental needs of the Covered Person; and
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by United HealthCare Services, Inc.; and
- consistent with the diagnosis of the condition; and
- required for reasons other than the convenience of the Covered Person or his or her Dentist; and
- demonstrated through prevailing peer-reviewed dental literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - safe with promising efficacy
    - ♦ for treating a life threatening dental disease or condition,

- in a clinically controlled research setting; and
- using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe a dental disease, sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this SPD. The definition of Necessary used in this SPD relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

Network – a group of Dentists who are subject to a participation agreement to provide Dental Services to Covered Persons. The participation status of Dentists will change from time to time.

Network Benefits – benefits available for Covered Dental Services when provided by a Dentist who is a Network Dentist.

Non-Network Benefits – coverage available for Dental Services obtained from Non-Network Dentists.

Open Enrollment – the period of time, determined by American Air Liquide Holdings, during which eligible Participants may enroll themselves and their Dependents under the Plan. American Air Liquide Holdings determines the period of time that is the Open Enrollment period.

Participant – an eligible person who is properly enrolled for Coverage under the Plan, as described under *Eligibility* in Section 2, *Introduction*. The Participant is the person (who is not a Dependent) on whose behalf coverage under the Plan is provided.

Plan – American Air Liquide Holdings Dental Plan.

Plan Administrator – American Air Liquide Holdings or its designee.

Plan Sponsor – American Air Liquide Holdings.

Procedure in Progress – all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Retired Employee – an Employee who retires while covered under the Plan.

Spouse – an individual to whom you are legally married.

Usual and Customary – Usual and Customary fees are calculated based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dentist would charge any similarly situated payor for the same services. In the event that a Dentist routinely waives Coinsurance and/or the Annual Deductible for benefits, Dental Services for which the Coinsurance and/or the Annual Deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with reimbursement policy guidelines. The reimbursement policy guidelines are developed following evaluation and validation of all Dentist billings in accordance with one or more of the following methodologies:

- as indicated in the most recent edition of the Current Dental Terminology (publication of the American Dental Association);
- as reported by generally recognized professionals or publications;
- as utilized for Medicare;
- as determined by dental staff and outside dental consultants; or
- pursuant to other appropriate source or determination.

SECTION 12 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:
- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the Dental Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 11, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

American Air Liquide Holdings is the Plan Sponsor and Plan Administrator of the American Air Liquide Holdings Health Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Dental Plan
American Air Liquide Holdings
12800 West Little York
Houston, TX 77041
(713) 624-8692

Claims Administrator

United HealthCare Services, Inc. is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
185 Asylum St.
Hartford, CT 06103-3408

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

American Air Liquide Holdings
12800 West Little York
Houston, TX 77041
(713) 624-8692

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:	American Air Liquide Holdings Health Benefit Plan
Plan Number:	501
Employer ID:	58-0939059
Plan Type:	Welfare benefits plan
Plan Year:	January 1, 2013 – January 1, 2014
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, trust agreements, collective bargaining agreements, summary annual reports, and other documents filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements, and copies of the latest summary annual reports, and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies; and
- receive a summary annual report of the Plan's financial activities. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You can continue dental care coverage for yourself, 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 Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are

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 Plan benefit or exercising your rights under ERISA.

If your claim for a Plan 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. See Section 6, *Claims Procedures*, for details.

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 summary 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 for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, 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, you may file suit in federal court. If it should happen that the 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.

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.

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 write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 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 at (800)-998-7542.

The Plan's Benefits are administered by American Air Liquide Holdings, the Plan Administrator. United HealthCare Services, Inc. is the Claims Administrator and processes claims for the Plan and provides appeal services; however, United HealthCare Services, Inc. and American Air Liquide Holdings are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network Dentist. United HealthCare Services, Inc. and American Air Liquide Holdings are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network Dentists.