Staples, Inc.

Delta Dental of Massachusetts
Dental PPO (Delta Dental Preferred Provider Organization)
Summary Plan Description

For Active Associates

Effective July 1, 2014

Table of Contents

About the Plan....1

Eligibility....2

- Associate Eligibility....2
- Eligible Family Members....2
- Qualified Medical Child Support Order (QMCSO)....4
- Genetic Information Nondiscrimination Act (GINA)....5

Enrollment Guidelines....6

- New Hires....6
- Annual Open Enrollment....6
- Special Enrollment Rules....6
- Cafeteria Plan Rules....7
- Changes in Family Status....7

When Coverage Begins....9

- Judgment, Decree, or Order, Including QMCSOs (Court Order)....9
- Changes in Coverage Under Another Employer Plan....9
- Change in Cost or Coverage....9
- Rehires....10

Information Sources....11

- Delta Dental of Massachusetts Toll-Free Care Line and Website....11
- Staples HR Services Toll-Free Line and Website....12

Basic Plan Features....13

- Member Rights and Responsibilities....13
- Receiving Treatment That Is Not Covered....13
- Reaching the Plan Year Maximum....13
- Avoiding Unexpected Dental Costs....14

Dental Plan Network....15

- Show Your ID Card....15
- Determining If a Dentist Participates in the Network....15
- Using a Network Dentist....15

Non-Delta Dental PPO Network Dentist Benefits 15
Important Terms 17
2014-2015 Benefits Schedule 18
Understanding Your Orthodontic Benefits 21
Orthodontic Coverage 21
Paying for Orthodontic Care 21
If You've Already Started Your Orthodontic Treatment 21
Termination of Orthodontic Coverage 21
Examples of Orthodontic Coverage 22
Limitations and Exclusions 24
Filing a Dental Claim 26
Filing a Claim When Visiting an Out-of-Network Dentist 26
How to File Your Dental Claim 26
Dental—Payment of Benefits—To Whom Payable 27
Coordination of Benefits (COB) 28
How COB Works 28
COB "Birthday Rule" 28
Right to Recover 29
No-Fault Motor Vehicle Coverage 29
Workers' Compensation 29
Subrogation 29
Right of Recovery 30
When Coverage Ends 31
Other Events Ending Your Coverage 31
How to Continue Coverage Under COBRA 32
COBRA at-a-Glance 32
Who Is Eligible for COBRA Coverage 34
Your Duties 35
Your Employer's Duties 35
Electing COBRA 35
Length of COBRA Coverage 36

Early Termination of COBRA Coverage 38
COBRA and FMLA 38
Cost of COBRA Coverage 39
Contacting Staples HR Services or the COBRA Administrator 39
Situations Affecting Your Benefits 40
Family and Medical Leave Act (FMLA) of 1993 40
Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 41
Trade Act of 2002 42
Use and Disclosure of Protected Health Information (PHI) Under HIPAA 43
Disclosure of PHI to the Plan Sponsor 44
Limitations of PHI Access and Disclosure 45
Benefits Claim Procedures 46
Filing a Claim 46
Denied Claims 46
Administrative and Legal Service Information 49
Additional Information About This Plan 49
Amendment or Termination of the Plan 50
Loss of Eligibility 51
Keep Staples Informed of Address Changes 51
Notice of Provider Directory/Networks 51
Your Rights Under ERISA 52

About the Plan

This Summary Plan Description (SPD) summarizes the Staples Dental Plan (the “Plan”), with details about your Delta Dental of Massachusetts Preferred Provider Organization (PPO) plan benefits as in effect July 1, 2014. If you enroll in a different plan, you may access an SPD for that option. The information in this booklet supersedes information communicated in prior booklets.

This Plan is self-insured. There is no insurance company to collect premiums or underwrite coverage. Instead, contributions from you and Staples pay all benefits. Prior claims experience and forecasted expenses are used to determine the amount of money needed to pay future benefits. These options are governed by federal laws, not by state insurance laws.

This dental option includes a network of dentists whose credentials have been reviewed by Delta Dental, and who have agreed to provide their services at negotiated rates. Your dental care is an important part of your overall health care. We encourage you to take advantage of the generous benefits offered in this program and get the quality dental care you need to maintain good oral health. You can generally reduce your out-of-pocket expenses by using network providers. However, you may choose to go out-of-network and expect to pay more because there are no discounts available when using an out-of-network provider.

🕮 **Note:** Delta Dental is the network manager and Claims Administrator for this coverage option.

Eligibility

Associate Eligibility

Generally, you are eligible to participate in this Plan if you are an active:

- Full-time exempt associate,
- Full-time non-exempt associate, or
- Part-time exempt associate.

You are not eligible if you are a(n):

- Associate whose employment is subject to the terms of a collective bargaining agreement, unless the agreement states inclusion in the Plan,
- Casual or temporary associate,
- Associate classified as an independent contractor,
- Intern,
- Retired associate, or
- Leased associate.

You will be considered in active service:

- On any of your scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Staples place of business or at some location to which you must travel to for your Staples business, or
- On a day that is not one of your scheduled work days if you were in active service on the preceding scheduled work day.

Eligible Family Members

You may also elect coverage for your eligible family members, including:

- **Your spouse (excluding common law spouse)**. A “spouse” will be defined as a person of the same or opposite gender to whom your marriage would be recognized as valid in one or more states. Former spouses are not eligible for coverage through Staples effective July 1, 2011, except on a temporary basis as required by COBRA.
- **Same-gender domestic partner**. If you reside in a state that does not recognize same-gender marriage, a same-gender domestic partner as defined below, and his/her children are eligible, if the domestic partner is covered by the Plan.
    - Same-gender domestic partner means a person of the same gender who satisfies all of the following requirements:
        - Shares your permanent residence,
        - Has lived with you for more than 12 months,
        - Is at least 18 years old,

- Is not a blood relative,
- Shares mutual responsibility for basic living expenses,
- Is not legally married to another person, and
- Has entered into a civil union or has registered as domestic partners, as determined by the state in which you live. If you live in a state where civil union or domestic partnership registration is not available to you, you may satisfy this requirement by completing a same-gender domestic partner affidavit.

In addition, you and your domestic partner will be considered to have met the terms of this definition as long as neither you nor your domestic partner:

- Has signed a domestic partner affidavit or declaration with any other person within 12 months before designating each other as domestic partners hereunder,
- Is currently legally married to another person, or
- Has any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

- If you reside in a state where same-gender marriage is currently legal, this section is not applicable to you; your same-gender partner is only eligible for benefits as a "spouse" as defined above. If the state in which you reside subsequently legalizes same-gender marriage after you have enrolled your same-gender domestic partner under the Plan, your same-gender domestic partner will be entitled to coverage for up to six months following the date same-gender marriage is legalized by the state.

  If you move to a state where same-gender marriage is legal after you have enrolled your same-gender domestic partner under the Plan, your same-gender domestic partner will be entitled to coverage for up to six months following the date of your move. In order for your same-gender domestic partner coverage to continue beyond these six-month periods, you must marry your same-gender domestic partner.

- **Your dependent children under age 26**. Coverage ends the day on which the child turns 26 years old.

  The term child is a person under the age of 26 who is your:

  - Natural child,
  - Stepchild,
  - Legally adopted child,
  - Child placed for adoption, or
  - Child for whom legal guardianship has been awarded to you or your spouse.

- **Dependent child(ren) of same-gender domestic partners.** This means a child of your domestic partner who is under age 26 or is disabled and who lives in the same residence permanently with you and your domestic partner.

- **Dependent child(ren) age 26 and older who are unable to care for themselves because of physical or mental disability**. Proof of the child's condition and dependence must be submitted to the Claims Administrator within 30 days after the date the child reaches this category. The Claims Administrator may ask, from time to time, for proof of continuation of such condition.

Dependent eligibility is subject to the following additional conditions and limitations:

- A dependent also includes a child for whom health care coverage is required through a "Qualified Medical Child Support Order" (QMCSO) or other court or administrative order. Staples is responsible for determining if an order meets the criteria of a QMCSO.
- A dependent does not include anyone who is also enrolled as an associate. No one can be a dependent of more than one associate. If your spouse is a Staples associate, he/she may enroll for "single" coverage or may be enrolled as a dependent under your coverage, but not both. Also, if you have children, each child can only be covered by one of you. A child who is an associate cannot be a dependent covered under you and also have his or her own coverage; he or she must choose one or the other.
- Benefits for a dependent child will continue until his/her 26th birthday occurs.

You will be asked to provide documents to prove that the family members you enrolled are eligible (e.g., marriage certificate, birth certificate). All dependents must meet the definition of eligible dependent and it is your obligation to ensure the accuracy of your dependent data. Should you enroll ineligible dependents and the Plan is made aware, any ineligible dependents will be removed from the applicable plans. You could also be responsible for any expenses incurred and paid for this individual. In this case, expenses would be reimbursed to the Plan and your employment may be terminated as a result of violating our Code of Ethics Policy.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't live with you. However, children who are no longer eligible (e.g., due to their age) cannot be added under a QMCSO.

Eligibility for Coverage under a QMCSO

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order and will not be considered a late entrant for dependent insurance.

When Staples is notified that a QMCSO has been issued for your eligible child, we will enroll your child and you, if you are not enrolled, per the instructions on the QMCSO. If you feel that the QMCSO has been issued in error, you must work with the issuing court or competent jurisdiction to provide Staples with the appropriate documentation to stop the deductions.

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 ("GINA") prohibits discrimination in group health plan coverage based on genetic information. GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and is effective for plan years beginning after October 9, 2009. HIPAA prevents a plan from imposing a pre-existing condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits, or premiums based on any health factor (including genetic information).

GINA prohibits group health plans from:

- **Basing premiums on genetic information.** However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.
- **Asking or requiring you to undergo a genetic test.** However, your health care provider may request a genetic test. In addition, genetic testing information may be requested to determine payment of a claim for benefits. However, the plan may request only the minimum amount of information necessary to determine payment. There is a research exception that permits a plan to request (but not require) that you or a covered family member undergo a genetic test.
- **Collecting genetic information (including family medical history) before or in connection with enrollment, or for underwriting purposes.** Plans are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a health risk assessment. There is an exception for incidental collection, provided the information is not used for underwriting. The incidental collection exception is not available if it is reasonable for the plan to anticipate that health information will be received in response to a collection, unless the collection explicitly states that genetic information should not be provided.

Enrollment Guidelines

New Hires

Staples will mail to your home address a personalized worksheet to guide you in your enrollment decisions as a new hire. The options you may choose from are determined by your home and work zip code. You make your election choices using the Staples enrollment website (associateconnection.staples.com).

🕮 **Note:** You must enroll everyone in the same option.

You must make an election on or before the deadline shown on your worksheet. If you fail to do so, you will be considered to have waived participation in this Plan for the current plan year and will have no coverage unless you make a new election as a result of a qualified event change or during the next enrollment period (whichever occurs first).

Annual Open Enrollment

Each spring, Staples offers an annual enrollment period. During this time, you may elect coverage, switch from your current option to another available option or drop coverage. This is also the time to add or remove family members. Eligible family members may be added or deleted for any reason during open enrollment.

Important: If a family member is no longer eligible, you must remove him/her from coverage.

When you elect coverage, you are automatically enrolled in the Pre-Tax (Section 125) Plan. This enables you to pay your premium contributions on a pre-tax basis. In return for this tax advantage, you may only enroll or change coverage during the annual open enrollment period or if you experience a change in family status (defined in the *Changes in Family Status* section).

If you fail to make an election before the open enrollment deadline, your default election will be your previous election (if already enrolled assuming the previously elected coverage remains available) or no coverage (if there was no previous election). If your previous election is no longer available, Staples may enroll you in an option of its choice or may require you to make another election. In the latter case, if you fail to make an election before the deadline, you will not have coverage.

Note that for the flexible spending accounts, your participation will stop if you do not make a new election each year (regardless of your previous election).

Special Enrollment Rules

If you decline enrollment for yourself or your dependents (including your spouse) because of other health coverage and you later lose that other coverage, you may be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 or 60 days (whichever is applicable; see the *Changes in Family Status* section for details) after the marriage, birth, adoption or placement for adoption by completing a Benefit Change Form and submitting it to Staples HR Services.

Also, if you or your dependents become ineligible for Medicaid or CHIP (Children's Health Insurance Program) and lose coverage, or if you or your dependents become eligible for a state's premium assistance program, you will have 60 days from the event date to complete a Benefit Change Form.

Cafeteria Plan Rules

Because this Plan is administered through a cafeteria plan arrangement in accordance with Section 125 regulations of the Internal Revenue Code, your premium contributions will be made on a pre-tax basis. Also, per this regulation, you are allowed to enroll or change coverage only during the annual open enrollment period. Exceptions are allowed if you experience a qualifying event and enroll or change your coverage due to the special enrollment rules.

Changes in Family Status

This section explains which events are considered changes in status and what changes you may make as a result. If you have a change in family status, you must submit a Benefit Change Form to Staples HR Services within 30 days. If you do not, your changes to your coverage may be limited.

If you elect not to participate in this Plan, you will not be able to enroll again until the next open enrollment period unless you experience a change in family status (as defined under Section 125 of the tax code) or qualify under the Health Insurance Portability and Accountability Act (HIPAA) "special enrollment rules." *Any changes in coverage due to "special enrollment rules" or change in status will take effect on the date that correlates to the special enrollment.*

The following is a quick reference guide to changes in family status and how your coverage is affected.

Important: You must submit a completed Benefit Change Form to Staples HR Services WITHIN 30 DAYS FROM THE QUALIFYING STATUS CHANGE EVENT (unless noted differently).

If This Event Occurs…	**How Coverage Is Affected**
Marriage/Domestic Partnership*/Registration*/ Civil Union*	You may elect or waive coverage, add or drop dependent(s) and/or change your Plan.
Divorce/Termination of Domestic Partnership*, Dissolution of Civil Union* or Registration* (You are enrolled in this Plan)	Your ex-spouse/domestic partner is no longer eligible for Staples group coverage on the date of divorce or termination of domestic partnership. 📖 **Note:** You may not drop coverage for yourself or other covered eligible family members.
Divorce/Termination of Domestic Partnership*, Dissolution of Civil Union* or Registration* (You are enrolled in this Plan or you lose coverage under your spouse's/domestic partner's plan)	You may enroll yourself and other family members who might have lost eligibility for your spouse's/domestic partner's plan.
Gain of a Dependent (through birth, adoption or placement for adoption, or guardianship)	You may enroll in this Plan and/or enroll him or her. You will have 60 days from the event date to submit a completed Benefit Change Form to Staples HR Services.
Dependent Becomes Ineligible	If your child is covered under this Plan, coverage for your child ends when he/she reaches age 26.
Death of a Dependent	You may elect or waive coverage, drop dependent(s) and/or change your Plan.

**Applies to same sex domestic partners only.*

When Coverage Begins

Once you elect coverage, it will become effective:

	New Hire	Open Enrollment	Employment Status Change (Part- to Full-time)	Family Status Change (FSC)
Exempt; also includes • Non-exempt retail management associates • Business consultants	First of the month following 30 days of service	July 1	Effective the date of the status change	Effective the date of the FSC
Non-exempt	First of the month following 60 days of service	July 1	Effective the date of the status change	Effective the date of the FSC

Judgment, Decree, or Order, Including QMCSOs (Court Order)

If a judgment, decree, or order (including a QMCSO) requires the Plan to provide coverage to your child, then Staples may automatically change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire. If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to Staples HR Services that such other person actually provides the coverage for the child.

Changes in Coverage Under Another Employer Plan

You may make a coverage election change if the plan of your spouse or dependent:

- Incurs a change such as adding or eliminating a benefit option,
- Allows election changes due to special enrollment, change in status, court order , or
- Has a different plan year than Staples.

Change in Cost or Coverage

If the cost of benefits increases or decreases during the plan year, Staples may, in accordance with the Plan's terms, automatically change your election contribution.

When the change in cost is significant, you may either increase your contribution or elect less costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit is added, you may change your election to the new benefit option.

You may be permitted to revoke and/or make new benefit elections, subject to the appropriate consistency rules, if one of certain specified events permitted by the Plan and IRS regulations occurs.

Rehires

If you are a rehire:

- More than six months after separation, the effective date is the same as the new hire guidelines stated above.
- Within six months of separation and the initial eligibility period was met, the effective date is the first of the month following rehire.
- Within six months of separation and the initial eligibility period was not met, the effective date is the first of the month following completion of the initial eligibility period.

Information Sources

Delta Dental of Massachusetts Toll-Free Care Line and Website

You may contact Delta Dental at any time as follows:

Phone Number:	**Mailing Address:**	**Web Address:**
Delta Dental Customer Service 1-800-872-0500 Monday – Thursday 8:30 a.m. to 8:00 p.m. Friday 8:30 a.m. to 4:30 p.m. EST (Eastern Standard Time) Interactive Voice Response (IVR) – available 24/7	Dental Claims: Delta Dental of MA P.O. Box 249 Thiensville, WI 53092	deltadentalma.com

Online Services

To register:

- Go to deltadentalma.com and click on “Members.”
- Click on “Login for Online Services” and then click on “Members” to register.
- Read and review the Terms and Conditions and click “Yes” to agree and continue.
- Complete the Register Member Personal Information section and continue on to complete the Account Information section..

Once registered, visit deltadentalma.com to better understand this Plan and make informed decisions on dentists and services. You can:

- Check your eligibility,
- Verify your deductible and annual maximum,
- Check the date of your last cleaning,
- View your benefit plan design,
- Check the status of your claims, and
- Request a new ID card.

You can also search for a dentist using the “Find a Dentist” feature. Just enter the Plan name, area preference, dentist name or specialty, and you will get a list of participating dentists.

Staples HR Services Toll-Free Line and Website

The Staples HR Services team provides an easy, single point of contact for your human resources and benefits questions, including payroll, HR policies and procedures, compensation, and taxes. HR Services team members are available year-round to help.

Phone Number:	**Mailing Address:**	**Web Address:**
1-888-490-4747 Monday - Thursday 8:30 a.m. to 8:00 p.m. Friday 8:30 a.m. to 7:00 p.m. EST (Eastern Standard Time) (except certain holidays)	Staples, Inc. Attn: HR Services 500 Staples Drive Framingham, MA 01702	associateconnection.staples.com

Online Services

Staples Sponsored Sites – Access to plan-related information including all Staples benefits, forms, guides and information for you and your family members is available at staples.com/benefits.

Basic Plan Features

The Delta Dental PPO plan, which is also referred to as the Delta Dental PPO with National Coverage plan, offers significant claim savings when compared to the Dental Indemnity plan. It also provides a higher benefit level when you receive care from one of the more than 165,000 participating dentist locations, and your dentist will complete and submit your claim forms for you.

Please refer to the *Benefits Schedule* section for a description of the types of services covered and limitations.

Member Rights and Responsibilities

As a Delta Dental member, you have the right to:

- Be provided with appropriate information about Delta Dental and its benefits, providers, and policies,
- Be informed of your diagnosis, the proposed treatment, and prognosis by your dentist,
- Give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment,
- Obtain a copy of your dental record, in accordance with the law, and
- Be treated with respect and have your dignity and need for privacy recognized.
- You have the responsibility to:
- Ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers,
- Provide dentists with the information necessary to care for you, and
- Be familiar with Delta Dental benefits, policies and procedures by reading Delta Dental's written materials or calling the Customer Service department at 1-800-872-0500.

Receiving Treatment That Is Not Covered

If you receive a treatment that is not covered by this Plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated network rate. Be sure to check the list of covered services before receiving any treatment.

Reaching the Plan Year Maximum

If you receive a treatment after you have exhausted your plan year maximum or if you receive a treatment that will cause you to exceed your plan year maximum, you may be billed the dentist's normal rate rather than Delta Dental's negotiated rate.

Avoiding Unexpected Dental Costs

There are a number of ways you can protect yourself from unexpected dental costs. We encourage you to:

- Confirm that the dentist you have selected still participates in the Delta Dental PPO network by calling the dentist's office or Delta Dental at 1-800-872-0500.
- Have your dentist submit a pre-estimate for any treatment that you consider costly. Delta Dental will send you an estimate of the benefit payment you will most likely receive for the treatment, which will help you estimate your out-of-pocket costs. (Delta Dental's estimate of the benefit payment is based on the status of your benefits when the pre-treatment estimate is processed – it is not a guarantee of payment).

Dental Plan Network

While you are not required to receive dental care from a network dentist, you will maximize your benefits when you visit one of the Plan's more than 165,000 locations. In addition:

- Network dentists accept discounted fees from PPO members, and you will pay much less when you visit a network dentist.
- Network dentists will prepare and submit claims for you.
- Delta Dental pays the dentist directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

Show Your ID Card

When you visit a dentist, present your identification card. This helps the provider confirm your eligibility and understand your benefits coverage.

📖 **Note:** Two identification cards will be mailed to your home shortly after your enrollment. Both cards will be issued in your name, but they can also be used by your spouse and covered dependents.

Determining If a Dentist Participates in the Network

To find out if the dentist you have selected is part of the Delta Dental PPO network, contact Delta Dental at 1-800-872-0500 or visit Delta Dental's website at deltadentalma.com.

Using a Network Dentist

This Plan is easy to use. Simply present your ID card to the network dentist during your visit. The dentist will prepare and submit your claim form to Delta Dental for you. Once the claim is processed, Delta Dental will send you an Explanation of Benefits (EOB) explaining how much they paid the dentist based on your coverage and any remaining balance, which you will pay directly to the dentist.

Non-Delta Dental PPO Network Dentist Benefits

This Plan provides coverage for dentists who do not participate in the Delta Dental PPO network. However, you will incur higher out-of-pocket costs than you would if you visited a network dentist. Benefit payments for non-network dentists are based on either the dentist's fee or the following - whichever is lower:

- Diagnostic services (Type I) are covered at 80%,
- Basic restorative services (Type II) are covered at 60%, and
- Major restorative services (Type III) are covered at 50%

Also, if you use the services of a non-participating dentist whose fees are higher than the allowable fees, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.

🕮 **Note:** For out-of-network dentists, non-network benefits are subject to a separate deductible and applies to Type II and III services.

Important Terms

Coinsurance

Coinsurance means the percentage of charges for covered services that you must pay under the Plan.

Deductibles

Deductibles are expenses to be paid by you or your dependent for the services received.

Accumulation of Plan Deductibles

Deductibles will not cross-accumulate between in- and out-of-network.

Out-of-Pocket Expenses

Out-of-pocket expenses are covered expenses incurred for in-network and out-of-network charges that are not paid by the Plan because of any deductible or coinsurance.

Balance Bill

Balance billing means that your out-of-network provider can bill you for any additional fees that you incur that are not covered by this Plan. Balance billing does not apply to in-network providers.

Participating Provider

Participating provider means a dentist, or a professional corporation, professional association, partnership, or other entity that is entered into a contract with Delta Dental to provide dental services at pre-determined fees.

Plan Year

The plan year is defined as July 1 – June 30. Each July 1st, your deductible is reset and begins to accumulate again.

2014-2015 Benefits Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK*
General Provision		
Plan Year Maximum	$1,250 per plan year per individual	$1,250 per plan year per individual
Plan Year Deductibles		
Individual	$50 per individual on Type II and III. Deductible does not apply to periodontal cleanings	$100 per individual on Type II and III. Deductible does not apply to periodontal cleanings
Family	$150 per family on Type II and III. Deductible does not apply to periodontal cleanings	$300 per family on Type II and III. Deductible does not apply to periodontal cleanings
Diagnostic and Preventive Services **Note:** Services paid by the Plan apply to the plan year maximum.		
Oral Exam	100% twice per plan year	80% twice per plan year
Comprehensive Evaluation	100% once every 60 months per dentist	80% once every 60 months per dentist
X-rays: • Full Mouth • Bitewing • Single Tooth	100% • Once every 36 months • Twice per plan year • As needed	80% • Once every 36 months • Twice per plan year • As needed
Cleanings	100% twice per plan year	80% twice per plan year
Fluoride Treatments	100% twice per plan year under age 19	80% twice per plan year under age 19
Sealants	100% for unrestored permanent molars, every 4 years per tooth through age 15; also covered for ages 16-19 for those who had a recent cavity and are at risk for decay	80% for unrestored permanent molars, every 4 years per tooth through age 15; also covered for ages 16-19 for those who had a recent cavity and are at risk for decay
Space Maintainers	100% for members under 14 and not for the replacement of primary or permanent anterior teeth	80% for members under 14 and not for the replacement of primary or permanent anterior teeth

**If you use the services of a non-participating dentist whose fees are higher than the allowable fees, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.*

******Important:*** *Orthodontic coverage is ONLY available when rendered by an in-network Delta Dental PPO dentist. In addition, for Massachusetts ONLY, Delta Dental Premier Massachusetts participating orthodontists are considered part of the PPO network.*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK*
Restorative		
Fillings • Silver (amalgam) • White (composite) • Temporary Stainless Steel Crowns	80% • Once every 24 months per surface per tooth • Once every 24 months per tooth • Once per tooth • Once every 24 months per tooth	60% • Once every 24 months per surface per tooth • Once every 24 months per surface per tooth • Once per tooth • Once every 24 months per tooth
Oral Surgery		
Simple Extractions	80% once per tooth	60% once per tooth
Surgical Extractions and Other Major Oral Surgery	80% once per tooth	60% once per tooth
Periodontics		
Periodontal Cleanings	100% once every 3 months following active periodontal treatment. **Note:** Cannot be combined with preventive cleanings.	80% once every 3 months following active periodontal treatment. **Note:** Cannot be combined with preventive cleanings.
Scaling and Root Planing	80% once in 24 months, per quadrant. No more than 2 quadrants are allowed on the same date of service.	60% once in 24 months, per quadrant. No more than 2 quadrants are allowed on the same date of service.
Periodontal Surgery	80% once every 36 months per quadrant.	60% once every 36 months per quadrant.
Endodontics		
Root Canal Treatment	80% once per tooth	60% once per tooth
Vital Pulpotomy	80% limited to deciduous teeth	60% limited to deciduous teeth

**If you use the services of a non-participating dentist whose fees are higher than the allowable fees, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.*

******Important:*** *Orthodontic coverage is ONLY available when rendered by an in-network Delta Dental PPO dentist. In addition, for Massachusetts ONLY, Delta Dental Premier Massachusetts participating orthodontists are considered part of the PPO network.*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK*
Prosthetic Maintenance		
Bridge or Denture Repair	80% once within 12 months, same repair	60% once within 12 months, same repair
Rebase or Reline of Dentures	80% once within 36 months	60% once within 36 months
Recement of Crowns and Onlays	80% once per tooth	60% once per tooth
Emergency Dental Care		
• Minor Treatment for Pain Relief • General Anesthesia	80% • For three occurrences in 12 months • Allowed with covered surgical services only	60% • For three occurrences in 12 months • Allowed with covered surgical services only
Prosthodontics		
Dentures	50% once within 60 months	50% once within 60 months
Fixed Bridges and Crowns	50% once within 60 months	50% once within 60 months
Implants	50% once per 60 months per implant. An endosteal implant is covered to replace one missing tooth (in lieu of a three unit bridge and when all adjacent teeth do not require crowns.)	50% once per 60 months per implant. An endosteal implant is covered to replace one missing tooth (in lieu of a three unit bridge and when all adjacent teeth do not require crowns.)
Major Restorative		
Crowns	50% once within 60 months per tooth when teeth cannot be restored with regular fillings	50% once within 60 months per tooth when teeth cannot be restored with regular fillings
Orthodontics**		
Full Course Treatment	50% of maximum plan allowance charges to age 19; $1,000 separate lifetime maximum	No coverage

**If you use the services of a non-participating dentist whose fees are higher than the allowable fees, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.*

******Important:*** *Orthodontic coverage is ONLY available when rendered by an in-network Delta Dental PPO dentist. In addition, for Massachusetts ONLY, Delta Dental Premier Massachusetts participating orthodontists are considered part of the PPO network.*

Understanding Your Orthodontic Benefits

Orthodontic Coverage

This Plan provides the following coverage for orthodontic services:

- Your coverage (50%) is based on the maximum plan allowable fee for orthodontic services.
- There is a lifetime maximum of $1,000 per eligible member.
- All members are eligible for coverage to age 19.
- There is a maximum of 24 months of active treatment.

Paying for Orthodontic Care

In most cases, Delta Dental issues reimbursements for orthodontic care in automatic monthly payments not to exceed 12 installments. The first payment is based on the date of banding/ placement of appliances. Additional payments will be issued automatically on a monthly basis assuming you are still eligible for orthodontic benefits.

If you begin orthodontic treatment after your effective date of coverage and you receive care from a network dentist, Delta Dental will reimburse your dentist directly and send you and your dentist an Explanation of Benefits (EOB). The EOB will detail any payments made to the dentist. It is up to you and your dentist to develop a payment plan for the balance minus any Delta Dental adjustments.

If You've Already Started Your Orthodontic Treatment

You are eligible for pro-rated orthodontic benefits for members who begin treatment before they join Delta Dental. If you've already started your orthodontic treatment before your coverage with Delta Dental begins, coverage will be based on your dentist's estimate of the cost of your total treatment and the time remaining in your treatment plan once your coverage with Delta Dental begins.

Coverage is subject to certain assumptions. First, consultations and banding are assumed to account for 30% of the allowable cost of treatment. Because that cost was incurred before your coverage began with Delta Dental, it is not covered.

This assumes that the remaining 70% of the allowable cost will result from active monthly treatments. Active monthly treatments you have remaining are covered while you are covered by Delta Dental.

These payments will be made in automatic monthly installments after the first pro-rated payment has been issued.

Termination of Orthodontic Coverage

In the event your coverage terminates before you complete your orthodontic treatment, the automatic monthly payments will cease.

Examples of Orthodontic Coverage

If you begin your orthodontic treatment while you are covered.

Consider the following example:

The dentist's fee	$4,200
Coverage level	50%
Amount covered (before lifetime maximum is applied)	$2,100
Lifetime maximum	$1,000
Delta Dental's payment (subject to the lifetime maximum)	$1,000
Patient responsibility (difference between the dentist's fee and Delta Dental's payment)	$3,200

If you begin your orthodontic treatment before you are covered.

You or your dentist need to provide Delta Dental with an estimate of the total cost of your treatment. Your coverage will be determined based on that estimate and the number of active monthly treatments you'll receive while you're covered by Delta Dental.

Consider the following example.

The dentist's fee	$4,200
Cost of consultation and banding (30% of the allowed fee: not covered)	$1,260
Cost of active treatments (70% of the allowed fee)	$2,940
Total months of active treatment (in the dentist's treatment plan)	24
Monthly cost for active treatments (cost of active treatment / months of active treatment)	$122.50

Months of treatment remaining (after your Delta Dental effective date of coverage)	13
Amount we base coverage on (monthly cost of active treatment x months remaining)	$1,592.50
Coverage level	50%
Amount covered (before lifetime maximum is applied)	$796.25
Lifetime maximum	$1,000
Delta Dental's payment	$796.25

If you have any questions about your dental or orthodontic coverage, please contact Delta Dental's Customer Service Department at 1-800-872-0500.

Limitations and Exclusions

This Plan provides benefits for any covered service that is necessary and appropriate, as determined by Delta Dental. Delta Dental will not provide benefits for a dental service that is not covered under the terms of your contract. In addition, the Plan will not provide benefits for a dental service that is not necessary and appropriate to diagnose or treat your dental condition, as determined by Delta Dental. To be necessary and appropriate, a service must be:

- Consistent with the prevention of oral disease or with the diagnosis and treatment of:
  - Those teeth that are decayed or fractured, or
  - Those teeth where the supporting periodontium is weakened by disease,
- In accordance with standards of good dental practice,
- Not solely for the convenience of you or your dentist,
- Not more costly than the services that are customarily provided (benefits will be based on the least costly method of treatment), and
- Generally accepted as appropriate for treating your condition.

Delta Dental determines what is necessary and appropriate on the basis of its review of dental records describing your condition and treatment. While Delta Dental may decide a service is not necessary and appropriate, it is based on the restrictions of your group's plan. It does not, in any way, suggest unnecessary or inappropriate treatment by your dentist. Delta Dental's decision is based specifically on the least costly, generally accepted method of treatment. Please note that you have a right to appeal decisions regarding your claim.


Tip: Benefits are paid only for the services listed in the *Benefits Schedule* section of this document. If a service is not listed there, you are not eligible for benefits for that service.

This Plan will not provide benefits for:

- A service or procedure that is not generally accepted as determined by Delta Dental,
- A service or procedure that is not described as a benefit in this summary plan description (SPD),
- Services that are rendered due to the requirements of a third party, such as an employer or school,
- Travel time and related expenses,
- An illness or injury that Delta Dental determines arose out of and in the course of your employment,
- Dental treatment that is primarily for cosmetic purposes,
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment,

- Treatment performed by anyone other than a duly licensed dentist, except for scalings or cleanings of teeth performed by a licensed dental hygienist under the supervision of a licensed dentist,
- A separate fee for services rendered by interns, residents, fellow or dentists who are salaried employees of a hospital or other facility,
- Treatment for temporomandibular joint (TMJ) syndrome,
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion,
- Restorations for reasons other than decay or fracture, such as erosion, abrasion, or attrition,
- Occlusal guards for the treatment of disorders of the joints of the jaw or for bruxism (grinding),
- Implants when not in lieu of a three unit bridge and transplants,
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss,
- Dental treatment that began before the member's coverage became effective or for dental treatment that continues after the member's coverage ends,
- A dentist's charge to you for any appointment that you miss,
- An illness, injury or dental condition for which benefits in one form or another are available, in whole or in part, through a government program or would have been available if you did not have insurance. A government program includes a local, state or national law or regulation that provides or pays for dental services. It does not include Medicaid or Medicare. Delta will not provide benefits if you could have received government benefits by applying for them within the appropriate agency's time limitation,
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests,
- Any dental services and supplies for which a charge would not have been made in the absence of dental coverage,
- Dental expenses for an injury for which you recover all or part from a third party who is liable for the injury, or
- All claims for benefits not submitted within one year of the date services were rendered.

Filing a Dental Claim

You or your beneficiary must file a claim in writing and within the time period prescribed in the specific plan, or within a reasonable period if none is specified, to the Claims Administrator for the plan under which you are claiming benefits. Please refer to the Information Sources section at the beginning of this document to contact the Plan for information on filing a claim. If your claim for benefits is denied, in whole or in part, you may appeal the denial using the procedures in the Filing an Appeal section of this document. Please note these procedures are different for health benefits, disability benefits, and life benefits under the Employee Retirement Income Security Act (ERISA).

The Claims Administrator has a specific amount of time to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act (ERISA) of 1974. The period of time the Claims Administrator has to evaluate and respond to a claim begins on the date the claim is first filed. Any claim made with respect to eligibility, participation, contributions, benefits or other aspects of the operation of the Plan should be made in writing to the Claims Administrator. The Claims Administrator will provide you with the necessary forms and make all determinations as to the right of any person to a disputed benefit.

Filing a Claim When Visiting an Out-of-Network Dentist

When you visit an out-of-network dentist you must complete and submit a claim form. Once the claim is processed, the payment will be sent directly to you, accompanied by an Explanation of Benefits (EOB) that explains the benefit payment.

Important: Out-of-network dentists may require you to pay for services at the time of treatment.

How to File Your Dental Claim

Claim forms are available by calling Delta Dental's Customer Service Department at 1-800-872-0500 or on-line at deltadentalma.com. Click on the Members icon and then the Forms link. All fully completed claim forms and bills should be sent directly to your servicing Plan Administrator's Claims Office.

Claim Reminders

- Be sure to use your Delta Dental member ID and account number when you file claim forms.
- Your member ID is the ID shown on your benefit identification card.
- Prompt filing of any required claim forms results in faster payment of your claims.

 **Warning:** Any person who knowingly presents a false of fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Dental—Payment of Benefits—To Whom Payable

Payments for covered services are automatically sent directly to participating dentists. If you receive services from a non-participating dentist, you may be required to pay the dentist up front for those services. To get reimbursed, you will need to complete and mail a claim form to Delta Dental.

Delta may, at its option, make payment to you for the cost of any covered expenses from a non-participating provider even if benefits have been assigned. When benefits are paid to you or your dependent, you or your dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of Delta is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If his legal guardian does not ask for payment, Delta may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, Delta may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by Delta Dental, they will have the right at any time to recover that overpayment from the person to whom or on whose behalf it was made, or offset the amount of that overpayment from a future claim payment.

Coordination of Benefits (COB)

If you are eligible for benefits under another group health plan (such as a plan sponsored by your spouse's employer), the two plans will coordinate their benefit payments so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB).

How COB Works

Under COB provisions, one group plan has primary responsibility and pays first. The other group plan has secondary responsibility and considers any additional benefits not covered by the primary carrier. Therefore, if the Plan is:

- Primary: It pays expenses as if no other insurance were involved.
- Secondary: It pays benefits only if you have not already received the full amount the Plan would pay if it were primary.

If the benefit is for…	Then this Plan is…
You as an active associate	Primary
You as a COBRA participant with benefits under another plan	COBRA coverage will be primary for limits and exclusions under the other plan
Your spouse	Secondary, if he or she is covered as an active employee through another employer's plan
Your dependent children	Primary or secondary as determined by the COB Birthday Rule

If the other group benefit program does not have a COB provision, these rules will not apply. In that case, the other group program is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

COB "Birthday Rule"

Under this rule, primary coverage for your dependent children will be the plan of the parent whose birthday occurs first in the calendar year, regardless of which parent is older. For example, if your spouse's birthday is in March and your birthday is in October, your spouse's plan will provide primary coverage for your children. If the decision cannot be made based on the birthday rule, the plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

- The plan of the parent with custody of the child,

- The plan of the stepparent whose spouse has custody of the child, and
- The plan of the parent not having custody of the child.

If a court decree declares one parent responsible for a child's health care expenses, payment will be made first under that parent's plan.

Right to Recover

If the Plan makes larger payments than are necessary under the COB provision or under any other provision, the Plan Administrator has the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made.

The Claims Administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the Plan.

The Plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in this Plan, the participant agrees to authorize the release of information the Plan Administrator requires to enforce these provisions.

No-Fault Motor Vehicle Coverage

If you (or your dependent) has coverage available to you under any no-fault motor vehicle coverage required by law, the no-fault motor vehicle coverage is primary. If you are covered for loss of earnings by both this Plan and any no-fault motor vehicle coverage required by law, any benefits the Plan pays because of a disability are reduced by the benefits available to you for loss of earnings according to the no-fault motor vehicle coverage.

Workers' Compensation

This Plan does not provide benefits if expenses are covered by workers' compensation or occupational disease law. This Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered by a workers' compensation or occupational disease law. Under those circumstances and before any payment from the Plan is made, the Plan Administrator may ask that you execute a subrogation and reimbursement agreement.

Subrogation

This section applies when another party is, or may be considered, liable for a covered person's injury, sickness or other condition (including insurance carriers who are so liable) and the Plan has provided or paid for benefits.

The Plan is subrogated to the rights of the covered person against any party (including any insurance carrier), liable for the covered person's injury or illness or for the payment for the treatment of such injury or occupational illness to the extent of the reasonable value of the benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of expenses.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Plan under this section.

The costs of legal representation retained by the Plan in matters related to subrogation will be borne solely by the Plan. The costs of legal representation retained by the covered person will be borne solely by the covered person.

Right of Recovery

If the Plan makes larger payments than are necessary under the COB provision or under any other provision, the Plan Administrator has the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made.

The Claims Administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the Plan.

The Plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in this Plan, the participant agrees to authorize the release of information the Plan Administrator requires to enforce these provisions.

When Coverage Ends

Circumstances that may result in disqualification, ineligibility, denial, loss, forfeiture or suspension of any benefits for you and your family include:

- You and your family members no longer meet the eligibility requirements,
- Your employment ceases,
- You are on military leave for more than a year,
- You are on an approved leave of absence for greater than six months over the course of a 12-month rolling calendar,
- You fail to make any required contributions, or
- Staples terminates the Plan.

🕮 **Note:** If you or any of your dependents lose coverage under a plan, contact HR Services to determine what arrangements, if any, may be made to continue your group coverage or to convert to any available individual coverage. Certain rights to continue health care coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) are outlined in the *How to Continue Coverage Under COBRA* section.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, or
- You commit an act of physical or verbal abuse that imposes a threat to Staples staff, the Claims Administrator's staff, a provider or another covered person.

🕮 **Note:** Staples has the right to demand that you pay back benefits Staples paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

How to Continue Coverage Under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your dependents may be eligible to continue health coverage (called "COBRA coverage") at group rates. This COBRA coverage is available in certain instances (called qualifying events) where coverage under the Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Plan ends. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the Plan. For more information, contact Staples HR Services at 1-888-490-4747.

COBRA coverage is provided subject to your eligibility for coverage as described below. Staples reserves the right to terminate your coverage retroactively if it's determined that you're ineligible under the terms of the Plan.

You will pay the entire cost of coverage—your share and Staples—plus a 2% administrative fee. There's a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

COBRA at-a-Glance

The following table provides an overview of available COBRA coverage. See the sections after the table for more details.

Who Is Affected	Qualifying Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	You leave employment for reasons other than gross misconduct	You and your dependents	Up to 18 months
	You experience a reduction in hours below the level required for benefit eligibility	You and your dependents	Up to 18 months
	You are disabled (for purposes of Social Security disability benefits) when you become eligible for COBRA or you become disabled within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your dependents	Up to 29 months*
Your Spouse or Dependent Child	You die	Your dependents	Up to 36 months
	You and your spouse become divorced or legally separated	Your dependents, including your former spouse	Up to 36 months
	Your spouse and/or dependent child is disabled when he/she becomes eligible for COBRA or becomes disabled within the first 60 days after an 18-month COBRA continuation coverage period begins	You and your dependents	29 months*
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to age)	Your dependent child	36 months

* *You must provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage.*

** *Only if this would cause your spouse or child to lose coverage under the Plan.*

Who Is Eligible for COBRA Coverage

If you are covered by the Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose coverage because of a reduction in your hours of employment or the termination of your employment (unless you are terminated because of gross misconduct on your part).

If you are enrolled in the Plan and terminate employment after a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you will not be returning to work after the leave or the last day of the FMLA leave period, whichever is earlier.

If your spouse is covered by the Plan on the day before the qualifying event, he or she is considered a qualified beneficiary. That means he or she has the right to choose COBRA coverage if he or she loses group health coverage under the Plan for any of the following reasons:

- You die,
- Your employment is terminated (for reasons other than your gross misconduct) or your hours of employment are reduced,
- You divorce from your spouse.

If your dependent children are covered under the Plan on the day before the qualifying event, they are also considered qualified beneficiaries. This means they have the right to COBRA coverage if their coverage under the Plan is lost for any of the following reasons:

- You die,
- Your employment is terminated (for reasons other than the your gross misconduct) or your hours of employment are reduced,
- You divorce, or
- Your child ceases to be a dependent child under the Plan.

If you elect continuation coverage and then have a child (either by birth, adoption or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, a new child who is a qualified beneficiary can be added to COBRA coverage by providing the COBRA Administrator, PayFlex, with a written notice of the new child's birth, adoption or placement for adoption. Send the written notice to PayFlex Systems USA, Inc., COBRA Department, P.O. Box 2239, Omaha, NE 68103-2239. This written notice should include information about your or the qualified beneficiary receiving COBRA coverage. The COBRA Administrator may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If you fail to notify the COBRA Administrator in a timely fashion (in accordance with the terms of the Plan), you will not be offered the option to elect COBRA coverage for the new child. Newly acquired eligible dependents (other than children born to, adopted by or placed for adoption) won't be considered qualified beneficiaries, but may be added to your COBRA coverage as dependents, according to the Plan's rules that apply to active associates.

Your Duties

Under the law, you or a family member have the responsibility to inform Staples HR Services, of a divorce or child's loss of dependent status under the Plan. This notice must be provided within 60 days from the latest of the:

- Date of divorce or loss of dependent status,
- Date coverage would normally be lost because of the event, or
- Date on which you were informed of the responsibility to provide the notice and of the Plan's procedures for providing such notice to the COBRA Administrator.

Notice must be provided to Staples HR Services, 500 Staples Drive, Framingham, MA 01702 or faxed to 508-305-1300. Notice must include information about you or your qualified beneficiary needing COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, you or your qualified beneficiary may be asked to provide HR Services with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

- **Divorce:** A copy of the divorce decree, or
- **Child no longer qualifying as a dependent:** A copy of a driver's license or birth certificate showing the child's age (in the case of a child's becoming too old for coverage).

If you or your family member fails to return the form and supporting documentation to HR Services during this 60-day notice period, any family member who loses coverage will not be given the option to elect COBRA coverage.

When HR Services is notified that one of these events has happened, Staples will notify the COBRA Administrator, PayFlex, to send out notification with your rights to elect COBRA coverage.

Your Employer's Duties

Qualified dependents will be notified of the right to elect COBRA coverage automatically (without any action required by you or your family member) if any of the following events that results in a loss of coverage occurs:

- You die,
- Your employment is terminated (for reasons other than your gross misconduct) or your hours of employment are reduced.

Electing COBRA

To elect or inquire about COBRA coverage, contact PayFlex at 1-888-678-7586.

Under the law, you must elect COBRA coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after PayFlex provides you with notice of your right to elect COBRA coverage. If you or a covered dependent doesn't choose COBRA coverage within the time period described above, you will lose the right

to elect COBRA coverage. You and your family members must reimburse the Plan for any claims mistakenly paid after the date coverage would normally have been lost.

If you choose COBRA coverage, Staples must give you coverage that, as of the time coverage is being provided, is made available under the Plan to similarly situated beneficiaries. “Similarly situated” refers to a current associate or dependent who hasn’t had a qualifying event. You’ll have the same opportunity to change coverage as active associates have. This also means that if the coverage for similarly situated or family members is modified, your coverage will be modified in the same way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or dependent child who is a qualified beneficiary is entitled to elect COBRA coverage even if you don’t make that election. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your coverage as an active associate ends. For dependents who no longer meet the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. However, coverage won’t take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If you lose group health coverage because of a termination of employment or reduction in hours, COBRA coverage may continue for you and your covered dependents for up to 18 months.

COBRA coverage for your covered dependents may continue for up to 36 months if coverage would otherwise end because:

- You die,
- You divorce, or
- Your dependent child loses eligibility for coverage.

Additional Qualifying Events

Additional qualifying events (such as a death or divorce) may occur while COBRA coverage is in effect. These events may result in an extension of an 18-month continuation period to 36 months for your covered dependents, but in no event will coverage last beyond 36 months from the date of the first qualifying event that originally made a qualified dependent eligible to elect coverage. The COBRA coverage period for your spouse and dependent children is 18 months from the subsequent termination or reduction of hours, whichever is longer, but not to exceed 36 months.

Under the law, in order to receive an extension of COBRA coverage, a qualified beneficiary must notify the COBRA Administrator, PayFlex at 1-888-678-7586, of the death of an associate, a divorce or a child’s losing dependent status under the Plan. This notice must be provided

within 60 days from the latest of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary is informed of the responsibility to provide the notice and of the Plan's procedures for providing such notice to the COBRA Administrator.

Notice of the additional qualifying event must be provided to the COBRA Administrator on the appropriate form, which may be obtained from the COBRA Administrator. The form should be returned to the COBRA Administrator at the address provided in the *Contacting Staples HR Services or the COBRA Administrator* section.

The notice must include information about you or your qualified beneficiary needing additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, you or your qualified beneficiary must provide the COBRA Administrator with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the Plan Administrator:

- **Death:** A copy of the death certificate,
- **Divorce:** A copy of the divorce decree, or
- **Child no longer qualifying as a dependent:** A copy of a driver's license or birth certificate showing the child's age (in the case of a child's becoming too old for coverage).

If a former associate or family member fails to provide the appropriate notice and supporting documentation to the COBRA Administrator during the 60-day notice period, the family member will not be entitled to extended COBRA coverage.

Special Rules for Disability

The 18 months of COBRA coverage may be extended to 29 months if you or your covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. This applies even to family members who are not disabled.

To benefit from the extension, the qualified beneficiary must provide the COBRA Administrator, PayFlex, with the disability determination within 60 days after the latest of (1) the Social Security Administration's determination of disability, (2) the date on which a qualifying event occurs, (3) the date coverage would normally be lost because of the event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Plan's procedures for providing such notice to the COBRA Administrator. This notice must be furnished to the COBRA Administrator before the end of the original 18-month COBRA coverage period. If a child is born to you or is placed for adoption with you while you're continuing coverage and the child is determined to be disabled within the first 60 days of COBRA coverage, the child and all family members with COBRA coverage arising from the same qualifying event may be eligible for a total of up to 29 months of COBRA coverage. If, during COBRA coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform the COBRA Administrator of this re-determination within 30 days of the date it is made or the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Plan's procedures for providing such notice to the COBRA Administrator. Coverage will terminate no earlier than the first of the month following the month that is 30 days after receipt of the notice that the individual is no longer disabled (if the 18 months provided to all COBRA eligible participants has been used).

Notice by the Social Security Administration of a determination of disability or a determination that you or a covered family member is no longer disabled must be provided to the COBRA Administrator on the appropriate form, which may be obtained from the COBRA Administrator. The notice must include information about you or your covered family member needing a disability COBRA coverage extension or notifying the COBRA Administrator that he/she is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and another qualifying event occurs within the 29-month continuation period, then the COBRA coverage period is 36 months after the termination of employment or reduction in hours. The qualified beneficiary must provide the appropriate notice to the COBRA Administrator as described under the *Additional Qualifying Events* section.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- Staples no longer provides group health coverage to any of its associates,
- The premium for COBRA coverage isn't paid on time (within the applicable grace period),
- The qualified dependent becomes covered—after the date COBRA coverage is elected—under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual, or
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave), and
- You do not return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you definitively inform Staples HR Services (1-888-490-4747) that you are not returning to work, or
- The end of the leave, assuming you do not return to work.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA Administrator will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level or in the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis. You have a grace period of at least 30 days.

Contacting Staples HR Services or the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact Staples HR Services at 1-888-490-4747 or the COBRA Administrator, PayFlex, at 1-888-678-7586.

You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Also, you must notify the COBRA Administrator in writing immediately at PO Box 2239, Omaha, NE, 68103, if:

- Your marital status has changed,
- You, your spouse or a dependent has changed address, or
- A dependent loses eligibility for dependent coverage under the terms of the Plan.

Situations Affecting Your Benefits

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision that provides the better benefit will apply.

Family and Medical Leave Act (FMLA) of 1993

Under FMLA, you may take up to 12 work weeks (unless the applicable state law in which you work provides for additional time) in a rolling 12-month period (measured backward from the beginning of the leave) of unpaid family or medical leave within any 12-month period to care for:

- A newborn child or newly placed adoptive or foster child (provided leave is completed within 12 months of the birth or placement),
- A spouse, parent or child who has a serious health condition,
- Your own serious health condition that prevents you from performing your job,
- For a "qualifying exigency" when a spouse, dependent or parent has been notified of an impending call to active duty status, or
- A one-time 26-week leave within a 12-month period to care for a spouse, dependent, parent, or next of kin who was injured in the line of duty during active duty status.

You are eligible for family and medical leave if you have worked for Staples for at least 12 months (need not be consecutive) and have worked at least 1,250 hours during the 12-month period preceding the start of the leave.

The way in which you may take family and medical leave depends on the qualifying circumstances:

- For a newborn, adopted or foster child, you must take leave during a continuous period unless Staples agrees to a different schedule.
- For serious health conditions, you may take a reduced workweek or intermittent leave if medically necessary.
- For illness that qualifies as short-term disability, the amount of time that you receive short-term disability benefits will count against the 12-week entitlement; if you are on unpaid family and medical leave, you may be required (or permitted) to substitute paid time off (vacation, floating holidays) to offset FMLA leave.

If you are on an approved FMLA leave, you have the option to continue active coverage as follows:

- You and your eligible family members can continue all health benefits during FMLA leave at the active associate contribution rate by paying premiums during the leave. If premiums are not submitted while on leave, Staples will take them as pre-tax deductions upon your return.
- You may return to active coverage after a family or medical leave without any pre-existing condition limits or waiting periods, even if you didn't continue benefits during the leave.

Additional information about your benefits under FMLA is described in Staples Leaves Policies.

Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994

Associates performing voluntary or involuntary duty in a “uniformed service” have certain rights under USERRA.

- If you are on uniformed services leave, you are entitled to the non-seniority benefits that would be made available to other associates with similar seniority, status, and pay, if they were on furlough or leave of absence.
- You and your dependents may continue your health coverage, at the associate rate, even if you are covered by military health care programs, up to one year in the uniformed services. After one year, you may continue your coverage for an additional 24 months at 102% of the total premium.
- You must notify Staples in advance of entering uniformed service. You should also notify Staples after you have left uniformed service.
- If you choose not to continue health coverage during this period of uniformed services leave, coverage can be reinstated without a waiting period or pre-exam, upon reemployment.

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes:

- Active duty,
- Active duty for training,
- Initial active duty for training,
- Inactive duty training,
- Full-time National Guard duty, and
- A period for which you are absent from a position of employment for an examination to determine your fitness for duty.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for workers displaced by the impact of foreign trade who, as determined by the U.S. Secretary of Labor, are eligible for a "trade readjustment allowance" or "alternative trade adjustment assistance" ("eligible TAA individuals"). Under this tax credit, if you're an eligible TAA individual, you're eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including COBRA coverage. If you're in this situation, you'll be notified.

The Trade Act of 2002 also created a special COBRA right applicable to TAA individuals. TAA individuals are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they didn't already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the TAA individual becomes eligible for assistance under the Trade Act of 2002. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ends.

If you have questions about this tax credit or your extended ability to elect COBRA coverage, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact.

Use and Disclosure of Protected Health Information (PHI) Under HIPAA

This Plan will use protected health information (PHI) to the extent of and consistent with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment for Health Care includes activities undertaken by the Plan (1) to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or (2) to obtain or provide reimbursement for the provision of health care and which relate to the individuals to whom health care is provided. These activities include, but are not limited to, the following:

- Determination of eligibility, coverage, and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim),
- Coordination of benefits,
- Adjudication of health benefit claims (including appeals and other payment disputes),
- Subrogation of health benefit claims,
- Establishing associate contributions,
- Risk adjusting amounts due based on enrollee health status and demographic characteristics,
- Billing, collection activities and related health care data processing,
- Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments,
- Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance and related health care data processing),
- Covered services reviews or reviews of appropriateness of care or justification of charges,
- Utilization review, including pre-certification, pre-authorization, concurrent review and retrospective review,
- Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan), and
- Reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

- Quality assessment,
- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions,
- Rating provider and plan performance, including accreditation, certification, licenses or credentialing activities,
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance),
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs, and
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.

Business Management and General Administrative Activities of the Plan, including, but not limited to:

- Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements,
- Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers,
- Resolution of internal grievances, or
- Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, after completion of the sale or transfer, will become a covered entity. The Plan will use and disclose PHI as required by law.

In accordance with HIPAA, the Plan will disclose PHI to Business Associates for purposes related to administration of this Plan.

Disclosure of PHI to the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the requirements identified below. The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law,
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI,

- Not use or disclose PHI for employment-related actions and decisions,
- Not use or disclose PHI in connection with any other benefit or associate benefit plan of the Plan Sponsor,
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware,
- Make PHI available to an individual in accordance with HIPAA's access requirements,
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
- Make available the information to provide an accounting of disclosures,
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA, and
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Limitations of PHI Access and Disclosure

In accordance with HIPAA, only associates in the following groups may be given access to PHI:

- Benefits Strategy and Design Group,
- Benefits Administration Group, and
- HR Services.

The persons described above may only have access to and use and disclose PHI for administration functions that the Plan Sponsor performs for the Plan.

If a person described above does not comply with this plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance as required by HIPAA.

Benefits Claim Procedures

Filing a Claim

All claims for benefits must be submitted to Delta Dental of Massachusetts within one year from the date the covered member received the services.

The Claims Administrator is responsible for providing you an explanation of benefits and information regarding your entitlement to a benefits and any amount payable to you.

The following categories of claims for benefits apply to the Plan, and according to the type of claim submitted your claim will be reviewed and responded to within a designated response time. If additional time (an extension) is needed to decide on your claim because of special circumstances, you will be notified within the claim response period.

If you have a problem with a Delta Dental benefit, contact Delta Dental's Customer Service Department.

Denied Claims

If your claim for benefits is denied completely or partially, you, your beneficiary, or designated representative will receive written notice of the decision. The notice will describe:

- The specific reasons for the claim's denial,
- References to the pertinent Plan provisions on which the denial is based,
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary, and
- A description of the Plan's review procedures (including any available external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal.

Depending on the type of claim, the explanation will also contain the following information:

- If the denial is based on an internal rule, guideline, or protocol, or standard, the denial will say so and state that you can obtain a copy of the rule, guideline, or protocol, free of charge upon request,
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the circumstances, or state that such an explanation will be provided upon request, free of charge, and
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims.

You should be aware that the Claims Administrator has the right to ask for repayment if a claim is overpaid for any reason.

Grievance Process

You, or your authorized representative, have the right to make inquiries and/or file a complaint with Delta Dental of Massachusetts.

If you wish to make an inquiry, file a complaint, or determine the status or outcome of utilization review decisions with Delta Dental, you can submit your inquiry or complaint to Delta Dental of Massachusetts in writing to:

Attention: Grievances
Delta Dental of Massachusetts
465 Medford Street
Boston, MA 02129

Your written appeal should include the reasons why you believe the benefit should be paid and information that supports, or is relevant to, your claim (written comments, documents, records, etc.). Your written appeal may also include reasonable access to, and copies of, all documents, records and other information relevant to your claim.

Internal Levels of Review

Internal Inquiry Process. Delta Dental will attempt to answer your questions and/or resolve concerns for all issues with the exception of reviews of an adverse determination. (If you request a review for an adverse determination, this will be handled through the internal grievance process.)

Internal Grievance Process. You may file a grievance by phone, in person, by mail or by electronic means. If an oral grievance has been presented, Delta Dental will request your grievance in writing and to be sent to Delta Dental within ten (10) business days, unless this timeframe has been waived or extended by mutual written agreement between both you and Delta Dental.

Delta Dental will send a written acknowledgement of their receipt of your grievance to you or your authorized representative, if any, within fifteen (15) business days of receipt. Delta Dental will provide you or your authorized representative, if any, a written resolution of a grievance within thirty (30) business days of receipt of the written grievance.

Written Decision

In the event that your grievance involves an adverse determination, Delta Dental's written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental practice and will:

- Identify the specific information upon which the adverse determination was based, and
- Reference and include applicable clinical practice guidelines and review criteria.

Reconsideration

Delta Dental will always provide you with the opportunity to have a final decision reconsidered where relevant information is received too late to review within the thirty (30) business day time limit or is not received but is expected to become available within a reasonable period.

Delta Dental will review the reconsideration and provide their written response to you as soon as possible following receipt of the additional information. Delta Dental agrees to provide a response no later than thirty (30) business days following your request for reconsideration.

Statute of Limitations

After you have received the response to the mandatory appeal, you may bring an action under section 502(a) of ERISA. Such action must be filed within one year of the date on which your mandatory appeal was decided. The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending.

Administrative and Legal Service Information

The Staples, Inc. Health & Welfare Benefit Plan (the "Plan") is a group health plan maintained to provide the benefits listed in the table below.

The vendors of fully insured benefit plans assume the risk for financing and providing all benefits under the contract. Staples, Inc. has no liability for any benefits due, or alleged to be due, under any such insurance contracts. Vendors that provide self-insured plans (some are referred to as third party administrators or TPAs) provide claims payments and other administrative services under an administrative services contract with Staples, but they do not assume any financial risk or obligation with respect to participant claims or the Plan.

Following is a list of current benefit vendors and administrative information for each plan.

Coverage/ Plan Type	Vendor/TPA Name	Funding Arrangement	Plan Year	Vendor/TPA Address	Source of Contributions
Dental: PPO, Indemnity, Out-of-Area	Delta Dental Plan of MA	Self-Insured	July 1 to June 30	465 Medford Street Boston, MA 02129	Employer and Associate
Pre-tax 125 Plan	Staples	Unfunded	July 1 to June 30	500 Staples Drive Framingham, MA 01702	N/A

Additional Information About This Plan

Plan Name

Staples, Inc. Health & Welfare Benefit Plan

Plan Number

501

Employer I.D. Number (EIN)

04-2896127

Type of Plan

This Plan is a health and welfare plan under ERISA providing dental benefits.

Plan Year

July 1 through June 30

Plan Funding

Benefits are funded through associate and employer contributions.

Plan Sponsor, Plan Administrator & Agent for Legal Service

Staples, Inc.
500 Staples Drive
Framingham, MA 01702
(508) 253-5000

Claims Administrator

The Claims Administrator provides information about claims payment. The Claims Administrator is Delta Dental of Massachusetts.

Claims Fiduciary and Appeals

The Claims Fiduciary is the person to whom all appeals are filed. The Claims Fiduciary is Delta Dental for dental appeals. You may contact the Claims Fiduciary as follows:

Dental Mandatory and Voluntary Appeals:
Delta Dental 465 Medford Street Boston, MA 02129

Amendment or Termination of the Plan

While Staples expects to continue this Plan, it reserves the right, at any time and for any reason, to amend or terminate the Plan, in whole or in part. Staples right to amend or terminate the Plan includes, but is not limited to, changes in the eligibility requirements, premiums or other associate payments charged, benefits provided and termination of all or a portion of the coverage provided under the Plan. If the Plan is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination and your rights will be reduced, terminated, altered or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan benefit, other than payment of any covered expenses you incurred prior to the plan amendment or termination. You will be notified of an amendment or termination of the Plan as may be required by law.

Loss of Eligibility

Everyone in your family may lose eligibility for coverage, and you may be subject to disciplinary action up to and including termination of employment if you commit fraud against the Plan, for instance, by filing claims for benefits to which you are not entitled. Coverage may also be terminated if you refuse to pay amounts erroneously paid by the Plan on your behalf or that you recover from a third party. Your participation may be terminated if you fail to comply with the terms of the Plan and its administrative requirements. You may also lose eligibility if you enroll persons who are not eligible, for instance, by covering children who do not meet the eligibility requirements.

Keep Staples Informed of Address Changes

To protect your and your family's rights, you should keep Staples informed of any changes in your and your family members' addresses. You should notify Staples HR Services at 1-888-490-4747, submit an eHelpdesk ticket or make the change through the Associate Connection (associateconnection.staples.com).

Notice of Provider Directory/Networks

You may obtain a list of providers who participate in the network by visiting or by calling the toll-free telephone number on your ID card.

Your participating provider networks consist of a group of local dental practitioners of varied specialties, as well as general practice, who are employed by or contracted with Delta Dental.

Your Rights Under ERISA

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

Receive Information About This Plan and Benefits

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

Continue Group Health Plan Coverage

- Continue health 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 will have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you ask for it before losing coverage, or if you ask for it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

- In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate this Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court after you have completed the administrative claim process. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan 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.

Assistance with Your Questions

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