Gangloff Industries, Inc.
Group Dental Plan

Document and Summary Description
Effective June 1, 2016

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ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Gangloff Industries, Inc. (the "Sponsor") as of June 1, 2016 hereby sets forth the provisions of the the Gangloff Industries, Inc. Group Dental Plan (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and any amendment is effective as of the date set forth in the amendment.

Adoption of the Plan Document

Gangloff Industries, Inc., as the settler of the Plan, hereby adopts this Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1 et seq. ("ERISA").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Document to be executed.

Gangloff Industries, Inc.

By: Randy R" Ferguson

Name: Randy R" Ferguson

Title: CEO/President

INTRODUCTION AND PURPOSE and GENERAL PLAN INFORMATION

Introduction and Purpose

Gangloff Industries, Inc. has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Participants in the Plan may be required to contribute toward their benefits.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for dental benefits. The Plan Document is maintained by Gangloff Industries, Inc. and may be inspected at any time during normal working hours by any Participant.

General Information

Name of Plan:	**Gangloff Industries, Inc. Group Dental Plan**
Plan Sponsor:	**Gangloff Industries, Inc. 1040 W Cty Rd 250 S Logansport, IN 46947 Phone: 574-722-8888**
Plan Administrator: (Named Fiduciary)	**Gangloff Industries, Inc.**
Plan Sponsor ID No.	**35-1864606**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Calendar/Plan Year:	**January 1 – December 31**
Plan Number:	**503**
Plan Type:	**Welfare Plan Providing Dental Benefits**
Effective Date:	**June 1, 2016**
Third Party Administrator:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance 2505 Court Street Pekin, IL 61558 Phone: 888-301-0747 Fax: 309-478-2912 Email: inquiry@groupplansolutions.com Website: www.groupplansolutions.com**

COBRA Notice:	**Group Plan Solutions Benefit Administration, a Division of Pekin Insurance** **COBRA** **2505 Court Street** **Pekin, IL 61558** **Phone: 888-301-0747** **Fax: 309-478-2912** **Email: inquiry@groupplansolutions.com** **Website: www.groupplansolutions.com**
Participating Employers:	**None**
Agent for Service of Process:	**Gangloff Industries, Inc.** **1040 W Cty Rd 250 S** **Logansport, IN 46947** **574-722-3888**

Legal Entity and Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

Applicable Law

This is a self-funded dental benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

This is a self-insured dental plan. The cost of the Plan is paid with contributions shared by the *employer* and the *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right:

- to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents
- to make determinations in regards to issues relating to eligibility for benefits
- to decide disputes that may arise relative to a Plan Participant's rights, and
- to determine all questions of fact and law arising under the Plan.

SCHEDULE OF BENEFITS

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of your Plan benefits.

SCHEDULE OF DENTAL BENEFITS		
Individual Maximum Benefit	Preventive, Basic, Major Restorative and Prosthodontic Services	$2,000 per calendar year
Calendar Year Deductible	Individual: $50	Family: $50 per Participant maximum of 3 Participants in one Family
Preventive Services	Covered expense is payable at 100%, not subject to the deductible.	
Basic Services	After deductible, covered expense is payable at 80%.	
Major Restorative Services	After deductible, covered expense is payable at 50%.	
Orthodontic Services	Not Covered	

Waiting periods and frequency/age limits may apply

NOTE: Certain services may be covered under your medical plan. The medical plan would pay as primary and the dental Plan would pay as secondary.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; however they may be used to identify ineligible expenses. Please refer to the appropriate sections of the Plan Document for that information.** There are also definitions located in other sections of this Plan Document.

ACTIVE FULL-TIME EMPLOYEE

Means a person employed by Gangloff Industries, Inc. or a Participating Employer on a permanent full-time basis. The person must work at least 30 hours per week.

ALLOWABLE EXPENSE

Means any Medically Necessary, Regular, Reasonable and Customary item of dental expense that is covered at least in part by any Group-Type Plan a Participant is covered under.

ADVERSE BENEFIT DETERMINATION

Adverse Benefit Determination shall mean any of the following:

- A denial in benefits;
- A reduction in benefits;
- A rescission of coverage;
- A termination of benefits; or
- A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

APPEAL

Means a review of an adverse benefit determination by the Third Party Administrator, as required under this Plan's claims and internal appeals procedures.

Once an authorized representative is appointed, the Third Party Administrator will direct all information and notification regarding the claim to the authorized representative. You will be copied on all notifications regarding decisions, unless you provide specific written direction otherwise.

AUTHORIZED REPRESENTATIVE

Means:

- a person to whom you have given express written consent to represent you in an external review, and includes your health care provider, or
- a person authorized by law to provide substituted consent for you, or
- your health care provider when you are unable to provide consent.

An Appointment of Authorized Representative form may be obtained from the Third Party Administrator. The completed form must be submitted to our Third Party Administrator at:

Group Plan Solutions
2505 Court Street
Pekin, IL 61558
FAX # 309-478-2912
Email Address: healthclaimappeal@groupplansolutions.com

An assignment for purposes of payment does not constitute appointment of an authorized representative under these claim procedures.

BENEFICIARY

Means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

BODILY INJURY

Means bodily damage other than a sickness, including all related conditions and recurrent symptoms. However, bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered a sickness and not a bodily injury.

BENEFIT PERIOD

The 12 month period during which deductible and coinsurance amounts apply. It begins on January 1 of a year and ends on December 31 of the year.

CALENDAR YEAR

Means a period of time beginning on January 1 and ending on December 31.

CALENDAR YEAR DEDUCTIBLE

Means the amount of Covered Expense for Basic or Major Dental Services that must be incurred in a Calendar Year by a Participant before any Covered Expense will be paid by Us. Covered Expense for Basic or Major Dental Services will be accumulated together to reach the Calendar Year Deductible shown in the Schedule Of Benefits.

CHILD, CHILDREN

Means the covered employee or covered employee spouses:

- natural born child;
- legally adopted child or child in the custody of the covered employee or employee's spouse while adoption proceedings are pending with respect to that child;
- step child; or
- any other child that has been declared the legal responsibility of the covered employee or covered employee's spouse.

The child must be under 26 years of age.

It also means the covered employee or covered employee's spouse's child who is 26 years of age or older, if the child meets the definition of Total Disability. The child must have become incapable before he/she became 26 years of age.

CLAIM

Means any request for a Plan benefit or benefits made in accordance with the claim procedures. A communication regarding benefits that is not made in accordance with the claim procedures will not be treated as a claim.

CLAIMANT

Means a Participant who makes a request for a Plan benefit or benefits in accordance with the claim and appeals procedures. Any reference to claimant in the section titled CLAIM AND APPEAL PROCEDURES also refers to an authorized representative of the Participant.

COINSURANCE

Means the designated percentage that the Plan will pay per Participant per benefit period in excess of any applicable deductible for covered expense. Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each Calendar Year.

CONCURRENT CARE CLAIM

Means a claim where an ongoing course of treatment that has been approved will be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

a. Where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; or
b. Where an extension is requested beyond the initially approved period of time or number of treatments.

COVERED EXPENSE

Means any Medically Necessary, Regular, Reasonable and Customary charges for dental services and supplies that are incurred by a Participant for the services stated in this Plan. The expense must be incurred while you are covered for that benefit under the Plan. Covered expenses are payable, after satisfaction of the deductible, if any, on a Maximum Allowable Fee basis at the coinsurance percentages and up to the maximum benefits shown on the Schedule of Benefits.

COVERED PERSON

Means the employee or any of the employee's eligible covered dependents enrolled for benefits provided under this Plan.

DEDUCTIBLE

Means the amount of Covered Expense that must be incurred in a Calendar Year by a Participant before any dental benefits are payable by the Plan:

- The amount is shown on the Schedule of benefits.
- After three Participants in one family have each satisfied the deductible amount during the same Calendar Year, the Deductible amount during the same Calendar Year, the deductible will be considered satisfied for all other covered family members for that Calendar Year.

Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

DEEMED EXHAUSTED

Means a claimant can initiate an external review because the Plan failed to strictly adhere to the internal appeal procedure. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable**.**

DENTIST

Means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and is operating within the scope of that license.

DEPENDENT

Means the child or children of the employee, who are not themselves covered as employees under this plan.

EFFECTIVE DATE

The date coverage is put in force or the date the Participant is added to this Plan.

EMERGENCY

Means the necessary procedures for treatment of pain and/or injury. Services include emergency procedures for treatment to the teeth and supporting structures.

EMPLOYEE

Means a common law employee of the Employer.

EMPLOYER

Means Gangloff Industries, Inc. or a Participating Employer.

ENROLLMENT DATE

Means the earlier of the date of enrollment of the individual in the Plan, or the first day of the waiting period of enrollment.

EXPENSE INCURRED

Means the actual fee charged for an incurred expense by a covered person.

EXPERIMENTAL/INVESTIGATIONAL

Means any drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of an Injury or Illness if one or more of the following criteria apply. The drug, biologic, device, diagnostic service, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use; or
- Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service or supply; or
- Is subject to review and approval of an Institutional Review Board or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service, or supply as

Experimental/Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, Treatment, service, or supply is under evaluation.

It also means any service, supply, or treatment that is not commonly and customarily recognized by the Physician's profession and within the United States as appropriate treatment of the patient's diagnosed Illness or Injury and determined to be of proven effectiveness by the appropriate National Scientific Organization related to the diagnosed Illness or Injury.

It also means any procedures, drugs, or devices with unproven efficacy. Unproven efficacy means that the procedures, drugs, or devices have not been used with sufficient frequency or have not achieved the requisite success rates to establish their safety and efficacy in the medical community. A procedure, drug, or device may be considered Experimental/Investigational for certain diagnoses and conditions, and considered established therapies for other diagnoses and conditions.

A medical treatment, procedure, drug or device that is approved through clinical trials will be considered experimental or investigational if reliable evidence shows it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its safety, efficacy, or its efficacy as compared with the standard means of treatment or diagnosis, and reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its safety, efficacy or efficacy as compared with the standard means of treatment or diagnosis, and/or approval has not been given by the United States Food and Drug Administration at the time it is furnished.

The fact that a procedure, drug, or device is the only available treatment for a condition will not make it eligible for coverage if it is Experimental/Investigational according to this definition.

EXTERNAL REVIEW

Means a review of an adverse benefit determination, including a final internal adverse benefit determination, under applicable federal external review procedures.

FAMILY STATUS CHANGE

A marriage, a birth, an adoption, or a child being place for adoption.

FINAL EXTERNAL REVIEW DECISION

Means a determination by an independent review organization at the conclusion of an external review.

FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

Means:

- An adverse benefit determination that has been upheld at completion of the Internal Appeal Procedures; or
- An adverse benefit determination for which the internal appeals procedures have been exhausted under the "deemed exhausted" rule in the Appeals procedure.

This Plan provides for two levels of appeal. Completion of the second level appeal with an adverse benefit determination will result in a final internal adverse benefit determination, and will trigger the right to an external review.

GROUP -TYPE PLAN

Means any of the following:

- Group or blanket insurance coverage;
- Pre-payment plans;
- Union Welfare plans;
- Plans growing out of an employee-employer relationship;
- Any statutory plans; or
- The medical benefits coverage in group automobile contracts, in group or individual automobile "no-fault" contracts, and in traditional automobile "fault" type contracts.

IMMEDIATE FAMILY

The Participant's spouse, children, parents, brothers and sisters.

INCURRED DATE

Means the date the date the dental service is furnished except Covered Expenses for:

- Fixed partial dentures, crowns, inlays, or onlays are incurred on the date the tooth is prepared;
- Root canal therapy is incurred on the date the pulp chamber is opened; and
- Prosthetic device is incurred on the date the master impression is made.

INDEPENDENT REVIEW ORGANIZATION

Means an entity that conducts independent external reviews of adverse benefit determinations and final internal adverse benefit determinations.

INJURY

Bodily injury caused by an accident.

MAXIMUM ALLOWABLE FEE

For a service means the lesser of:

1. The fee most often charged in the geographical area where the service was performed;

2. The fee most often charged by the provider;

3. The fee which is recognized as reasonable by a prudent person;

4. The fee determined by comparing charges for similar services to a national data base adjusted to the geographical area where the services or procedures were performed; or

5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and services relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the service, as adjusted to the geographic area where the services or procedures were performed.

MAXIMUM BENEFIT

Means the maximum amount that may be payable for each covered person, for expense incurred. The applicable maximum benefit is shown on the Schedule of Benefits. No further benefits are payable once the maximum benefit is reached.

MEDICALLY NECESARY

Means treatment that:

- Is not Experimental/Investigational in nature;
- Is not done mainly as a convenience to the patient or provider;
- Is commonly accepted as proper care or treatment of the condition by the American dental community;
- Is performed solely for the benefit of the patient; and
- Meets professionally recognized national standards of quality.

MEDICARE

Means Title XVIII of the Social Security Act as amended.

MEDICAID

Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act as amended.

MINOR

Means a person who is under the legal age of competence.

NEWBORN CHILD

A dependent child born to the employee while the employee is a Participant under this Plan.

PARTICIPANT

Means any individual who is covered for benefits under this Plan.

PHYSICIAN

Means a practitioner of the healing arts, licensed by the state he/she practices in. He/she must be performing only those services he/she is licensed to perform.

PLAN ADMINISTRATOR

Means the person named in the documents describing the Plan as responsible for the operation and administration of the Plan. If no such person is designated, then the employer is the Plan Administrator. The Plan Administrator under this Plan is Gangloff Industries, Inc.

PLAN SPONSOR

Means a designated party, usually a company or employer, that sets up a dental plan for the benefit of the organization's employees and is responsible for ensuring a source of funding for Plan benefits. The Plan Sponsor under this Plan is Gangloff Industries, Inc.

POST-SERVICE CLAIM

Means any claim for a benefit under a group dental plan that is not a pre-service claim.

PREDETERMINATION OF BENEFITS

Means a review by the Third Party Administrator of a dentist's planned treatment and expected charges, including diagnostic charges, prior to the rendering of services.

PRE-SERVICE CLAIM

Means a claim with respect to which the terms of the Plan condition receipt of a Plan benefit, in whole or in part, on approval of the benefit by the Third Party Administrator in advance of obtaining dental care.

PROOF OF LOSS

Means any information that We consider necessary to establish Your dental benefits. This includes, but is not limited to, claim forms, medical records, and any other information We need to determine benefits.

PROTECTED HEALTH INFORMATION

Means individually identifiable health information about a covered person, including: (a) patient records, which includes but is not limited to all health records, dentist and provider notes and bills and claims with respect to a covered person; (b) patient information, which includes patient records and all written and oral information received about a covered person; and (c) any other individually identifiable health information about covered persons.

REGULAR, REASONABLE & CUSTOMARY

Means the lessor of:

- The actual charge;
- What the provider would accept for the same service or supply in the absence of insurance;
- The reasonable charge as determined by Plan, based upon the Regular, Reasonable, and Customary percentile level purchased by You and factors deemed appropriate by the Plan.

SCHEDULE OF BENEFITS

A list which states those benefits that the Plan Administrator has decided to provide to participants.

SPACE MANAGEMENT

Means the installation of fixed or removable appliances designed to maintain space by keeping adjacent and opposing teeth from moving, when teeth are prematurely lost or extracted.

SPOUSE

Means a party to a legal marriage.

THIRD PARTY ADMINISTRATOR

Means Group Plan Solutions (GPS). The Third Party Administrator provides services to the Plan Administrator, as defined under the Plan Management Agreement. The Third Party Administrator is not the Plan Administrator or the Plan Sponsor.

SERVICES

Means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

SUMMARY PLAN DESCRIPTION (SPD)

Means the document provided by the employer which outlines the benefits, provisions and limitations of this Plan.

URGENT CARE CLAIM

Any pre-service claim for dental care or treatment where, in the opinion of a physician with knowledge of the claimant's medical condition, a delay in determining if the service is approved under the Plan could seriously jeopardize the claimant's life or health, or ability to regain maximum function.

Upon receipt of a pre-service claim, the Plan Administrator will make a determination if it is an urgent care claim. However, if a physician with knowledge of the claimant's medical condition determines that the claim is an urgent care claim, the Plan will treat the claim as an urgent care claim.

YOU, YOUR

Means a Plan Participant.

DENTAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

This section describes benefits for Covered Expenses. Covered Expense means Expense Incurred by You for the services stated within. The expense must be incurred while you are covered for that benefit under the Plan. Covered Expenses are payable, after satisfaction of the deductible, if any, on a Maximum Allowable Fee basis at the coinsurance percentages and up to the Maximum Benefits shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each covered person each calendar year. Only charges which qualify as a Covered Expense may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all Covered Persons in one (1) family in a Calendar Year is subject to the maximum shown on the Schedule of Benefits.

COINSURANCE

Coinsurance means the shared financial responsibility for Covered Expenses between the Covered Person and the Plan.

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each Calendar Year.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

Eligibility for Employee Coverage

All Active Full-Time Employees are eligible to become covered under the plan once they have completed 60 consecutive days as a full-time employee. An Active Full-Time Employee must be enrolled in the Gangloff Industries, Inc. Health and Welfare Benefit Plan to be eligible to enroll in this Plan.

Effective Date for Employee Coverage

An Active Full-Time Employee will become covered under the Plan the day following the day they meet the Eligibility Requirements above if he submits an enrollment form within 31 days of the date he is eligible to become covered.

Eligibility for Dependent Coverage

An employee's dependents are eligible to be covered under this Plan on the earliest of the following dates:

- The date the employee becomes covered under this Plan;
- The first date the employee has an eligible dependent.

The employee must enroll any eligible dependents within 31 days of the date they are first eligible for them to become covered as a dependent under the Plan.

A person cannot be covered as both a dependent and an employee under the Plan. A dependent child cannot be covered as a dependent of more than one Employee who is covered under the Plan. An Employee's Spouse is not eligible to be covered under the Plan.

Newborn Children

A newborn child is covered from the moment of birth. In order for coverage to extend beyond the first 31 days after birth, you must submit an enrollment form for the newborn within 31 days after the newborn's birth.

SPECIAL ENROLLMENT PERIODS

For Persons Who Previously Declined Coverage

A person who previously declined coverage in writing because they were covered under another group health plan or health insurance coverage may have a 31 day special enrollment period if they lose that coverage.

The 31 day special enrollment period will begin for that person on the day the person experiences a loss of eligibility for coverage. The person must submit a special enrollment form during that time to become covered by the Plan.

Coverage will become effective on the first of the month following the date the person applies.

Due to a Change in Family Status

A person will have a 31 day special enrollment period to apply for coverage beginning on the date a family status change occurs. The person must submit a special enrollment form during that time to become covered by the Plan.

In the case of a family status change due to marriage, coverage will begin on the first day of the month, after the special enrollment form is received, as long as enrollment occurs within the 31 day special enrollment period.

In the case of a family status change due to the birth of a dependent child, coverage will begin on the child's date of birth, after the special enrollment form is received, as long as enrollment occurs within the 31 day special enrollment period.

In the case of a family status change due to adoption or placement for adoption, coverage will begin on the date of the adoption or placement for adoption, after the special enrollment form is received, as long as enrollment occurs within the 31 day special enrollment period.

Qualified Medical Child Support Order

The plan administrator will enroll for immediate coverage under this Plan any alternate recipient who is the subject of a Medical Child Support Order that is a Qualified Medical Child Support Order ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient means any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a participant.

Medical Child Support Order means any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to a Participant's child or directs the participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice or "NMSN" means a notice that contains the following information:

- Name of an issuing State agency
- Name and mailing address (if any) of an employee who is a Participant under the Plan
- Name and mailing address of one or more alternate recipients, and
- Identity of an underlying child support order.

Qualified Medical Child Support Order or "QMCSO" is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the Participant and the name and mailing address of each such alternate recipient covered by the order
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined
- The period of coverage to which the order pertains, and
- The name of this Plan.

In addition, a NMSM shall be deemed a QMCSO if it:

- Contains the information outlined in the definition of National Medical Support Notice
- Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and Plan Administrator will assume that all are designated
- Informs the Plan Administrator that, if a group health plan has multiple options and the participant

is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any)
- Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as qualified if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible plan participants without regard to this section, except to the extent necessary to meet the requirements of a State law relating to medical child support orders, as described in Social Security Act §1098 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:
- Notify the Participant and each alternate recipient covered by the Order in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO, and
- Make an administrative determination if the order is a QMCSO and notify the Participant and each alternate recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:
- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
    - Whether the child is covered under the Plan, and
    - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage, and
- Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:
- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice, and
- Permit any alternate recipient to designate a representative for receipt of copies of the notices that are sent to the alternate recipient with respect to the Order.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances;
- The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan with (60 days) after the termination; or
- The Employee or Dependent become eligible for a contribution/premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee request coverage under the Plan within (60 days) after eligibility is determined

Open Enrollment

Once annually Employees will have a choice of enrolling in this Plan. Employees will be notified in advance when the open Enrollment Period is to begin and how long it will last. If Employee declined coverage at the time they were initially eligible for coverage, the Employee will be able to enroll during the Open Enrollment Period. You must be enrolled in the Gangloff Industries, Inc. Health and Welfare Benefit Plan to be eligible to enroll in this Plan.

TERMINATION OF COVERAGE

Termination Dates of Employee Coverage

The coverage of any Employee under this Plan will end on the earliest of the following dates:

- the date this entire Plan terminates;
- the last day of the month coinciding with or next following the date he/she requests coverage be terminated, as long as the request is made on or before the date requested;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for coverage when it is due;
- the last day of the month coinciding with or next following the date he/she ceases to be eligible for coverage under the Plan;
- the last day of the month coinciding with or next following the date his/her employment is terminated; or
- immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under this Plan will end on the earliest of the following dates:

- the date this entire Plan terminates;
- the date coverage for Dependents is discontinued under this Plan;
- the date the Employee's coverage under this Plan ends;
- the last day of the period for which the Employee has made a contribution, if he/she fails to make a required contribution for Dependent coverage when it is due;
- In the case of a child age 26 or older, for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest of:
    - The date of cessation of such inability;
    - The date proof of the uninterrupted continuance of such inability is not provided, including failure to submit to any requested examination;
    - The date the child is no longer dependent on the Employee for his or her support;
- the last day of the month coinciding with or next following the date such person ceases to be a Dependent as defined in this Plan, except as may be provided for in other areas of this section; or
- Immediately after an Employee or his/her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Continuation During Family and Medical Leave

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Participants under certain specified conditions.

A covered employee who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his covered dependents. Benefits under the Plan are available to the same extent as if the Covered Employee had been actively at work during the entire leave period, subject to the following terms and conditions:

- Coverage shall cease for a Covered Employee (and his covered dependents) for the duration of the leave if at any time the Covered Employee is more than 30 days late in paying any required contribution.
- A covered employee who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.
- If a covered employee who is a key employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the key employee's entitlement to Plan benefits continues unless and until the covered employee advises

the employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

- Any portion of the cost of coverage which had been paid by the covered employee prior to the leave must continue to be paid by the covered employee during the leave. If the cost is raised or lowered during the leave, the covered employee shall pay the new rates. If the leave is unpaid, the covered employee and the employer shall negotiate a reasonable means for paying the covered employee's portion of the cost.
- If the employer provides a new health plan or benefits or changes the health benefits or Plan while the covered employee is on leave, the covered employee is entitled to the new or changed Plan and benefits to the same extent as if the covered employee were not on leave.
- The employer may recover its share of the cost of benefits paid during a period of unpaid leave if the covered employee fails to return to work after the covered employee's leave entitlement has been exhausted or expires, unless the reason the covered employee does not return to work is due to:
    - The continuation, recurrence, or onset of a serious health condition which would entitle the covered employee to additional leave under the FMLA, or
    - Other circumstances beyond the covered employee's control.

If a covered employee fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the employer from recovering its share of the cost of benefits paid on the covered employee's behalf during a period of unpaid leave, the employer may require medical certification of the covered employee's or the covered dependent's serious health condition. The covered employee is required to provide medical certification within thirty days from the date of the employer's request. If the employer requests medical certification and the covered employee does not provide such certification in a timely manner, the employer may recover the costs of benefits paid during the period of unpaid leave.

Employees on Military Leave

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

- The maximum period of coverage of a person under such an election shall be the lesser of:
    - The 24 month period beginning on the date on which the person's military leave begins, or
    - The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.
- An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not be terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

DENTAL BENEFITS

The Plan's payment of dental benefits is subject to all definitions, provisions, limitations, and exclusions contained in this Plan. Benefits will be payable only for Covered Expense. Benefit payments for a Participant in a Calendar Year will not exceed the Maximum Benefit Amount shown in the Schedule of Dental Benefits and described in the Exclusions & Limitations provision. Basic and Major Dental Services will not be paid until the Calendar Year Deductible has been met.

AMOUNT OF BENEFIT FOR COVERED DENTAL EXPENSES

The following services will be considered covered dental services.

Preventative Dental Services

The Plan will pay 100% of Covered Expense for Preventive Dental Services. The following are considered to be Covered Expense for Preventative Dental Services:

- Office visits and examinations
  - Up to 2 periodic oral exams for each Participant in a Calendar Year;
  - Emergency treatment to relieve dental pain or other non-routine, unscheduled visits, but only if no other service, except X-rays, is rendered during the visit.
- X-rays
  - Up to 4 bitewing X-ray films in a Calendar Year;
  - One set of full mouth X-rays, including bitewings, or Panoramic film - maxilla and mandible, but only one set per Participant in any 3 Calendar Years;
  - Other intraoral periapical or occlusal films – single films;
  - Extraoral superior or inferior maxillary film
  - Panoramic film, maxilla and mandible, but only one per Participant in any 3 Calendar Years.
- Dental prophylaxis and fluoride treatments
  - Up to 2 routine prophylaxis per Participant in a Calendar Year;
  - Up to 2 fluoride treatments in a Calendar Year, but only for Participants under the age of 19.
- Topical application of a sealant on an unrestored permanent molar, but only for a Participant less than 16 years of age, and limited to one treatment per tooth in any 36 consecutive months.
- Space Management for a Participant under the age of 16 and limited to initial appliance only (includes all adjustments within 6 months after installation)
  - Fixed, unilateral, band or stainless steel crown type
  - Removable, bilateral type
- Fixed and removable appliances to inhibit thumb sucking
  - Only for an Participant under the age of 14;
  - Limited to the initial appliance only (includes all adjustments in the first 6 months after installation).

Basic Dental Services

The Plan will pay 80% of Covered Expense for Basic Dental Services after the Calendar Year Deductible has been met. The following are considered to be Covered Expense for Basic Dental Services:

- Office visits and examinations for diagnostic consultation with a dentist other than the one providing treatment
  - Limited to one consultation for each dental specialty in any Calendar Year;
  - Only if no other service is rendered during the visit.
- Tests and laboratory examinations
  - Bacteriologic cultures;
  - Caries susceptibility tests;
  - Biopsy and examination of soft oral tissue;
  - Pulp vitality tests;
  - Diagnostic casts.
- Restorative services
  - Amalgam, silicate, or resin-based composite fillings
  - Stainless steel crowns;
  - Resin crowns, without metal;
  - Pin retention, in addition to restoration;
  - Recementation of inlays, onlays, crowns or bridges.

- Endodontic services – excludes final restoration
  - Pulp capping;
  - Vital pulpotomy;

- Endodontic therapy of nerve-dead teeth (includes treatment plan, clinical procedures, and follow-up care);
- Apexification/recalcification;
- Apicoectomy, as separate procedure or in conjuction with other endodontic procedures;
- Retrograde filling;
- Root amputation.

- Periodontic services
  - Gingivectomy or gingivoplasty;
  - Gingival flap procedure including root planning;
  - Sub-gingival curettage and root planning;
  - Mucogingival surgery;
  - Bone replacement graft;
  - Guided tissue regeneration;
  - Osseous surgery, including flap entry and closure;
  - Osseous grafts, including flap entry, closure and donor sites;
  - Provision splitting;
  - Pedicle or free soft tissue grafts, including donor sites;
  - Occlusal adjustment, when done in conjunction with periodontal surgery;
  - Periodontal scaling and root planning.
- Oral surgery
  - Extractions (includes local anesthesia, suturing if needed, and routine postoperative care);
  - Root Recovery;
  - Oral antral fistula closure;
  - Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
  - Surgical access or surgical exposure of an unerupted tooth to aid eruption;
  - Mobilization of erupted or malpositioned tooth to aid eruption;
  - Biopsy of oral tissue;
  - Surgical repositioning of teeth;
  - Alveoloplasty;
  - Stomatoplasty;
  - Vestibuloplasty;
  - Osteoplasty-Removal of:
    - Lateral exostis;
    - Torus palatiunus;
    - Torus mandibularis.
  - Removal of cyst or tumor;
  - Incision and drainage of abscess;
  - Frenectomy;
  - Sialolithotomy for removal of salivary calculus;
  - Excision of hyperplastic tissue;
  - Primary closure of a sinus perforation;
  - Suture of soft tissue injury;
  - Closure of salivary fistula;
  - Dilation of salivary duct;
  - Partial ostectomy/sequestrectomy for osteomyelitis or superficial bone abscess;
  - Maxillary sinusotomy for removal of tooth fragment or foreign body;
  - Surgical excision of soft tissue lesions;
  - Surgical excision of intra-osseous lesions;
  - Surgical reduction of osseous tuberosity;
- Prosthodontic services
  - Adjustments to existing dentures;
  - Repair complete or partial broken denture;
  - Add tooth to existing denture;
  - Denture rebase or reline if more than 6 months following the placement of the denture;
  - Tissue conditioning if more than 6 months following the placement of the denture;

    - Recement bridge;
    - Repair bridge;
    - Repair crowns;
    - Recement inlay;
    - Add clasp to existing partial denture;
    - Post removal.
- Other services
    - General anesthesia in conjunction with surgical procedures
    - Antibiotic drug injection;
    - Sedative filling.

Major Dental Services

The Plan will pay 50% of Covered Expense for Major Dental Services after the Calendar Year Deductible has been met. The following are considered to be Covered Expense for Major Dental Services:

- Restorative services
    - Inlays;
    - Onlays;
    - Crowns and posts;
        - Resin with metal;
        - Porcelain or porcelain with metal;
        - Full cast metal (other than stainless steel);
        - 3/4 cast metal (other than stainless steel);
        - Cast post and core, in addition to crown;
        - Core build-up including any pins;
        - Steel post and composite or amalgam core, in addition to crown;
        - Cast dowel pin;
        - Crown buildup with Pin retention.
- Prosthodontic services
    - Fixed bridge
    - Bridge abutments
    - Bridge Pontics
    - Fixed partial denture;
    - Fixed partial denture retainers;
    - Fixed partial denture pontics;
    - Stress breakers;
    - Dentures (allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation);
        - Complete dentures, upper or lower;
        - Partial dentures.
- Implant services
    - Surgical placement of implant body; endosteal implant;
    - Abutment placement or substitution: endosteal implant;
    - Surgical placement: eposteal implant;
    - Surgical placement: transosteal implant.
- Implant supported prosthetic
- Other implant services
    - General anesthesia in conjunction with surgical procedures;
    - Repair implant supported prosthesis;
    - Repair implant abutment;
    - Implant removal.

IF THIS PLAN REPLACES ANOTHER DENTAL PLAN

If this Plan is replacing another dental plan the Participant had with another employer, We will pay for Covered Expense to replace teeth that were lost or to complete dental work that was started before the Effective Date if:

- The Participant was covered under the former Plan and has been continuously covered under this Plan since the Plan's effective date; and
- The former Plan provided benefit for the expense.

We will pay the lessor of:

- What the former Plan would have paid; or
- What this Plan would otherwise pay.

We will deduct any benefits paid by the former plan from our benefit payment.

PRE-DETERMINATION OF DENTAL BENEFITS

If the dental treatment to be performed is expected to exceed $200.00, the expense should be submitted to the Plan for review before the treatment is performed. We will then estimate the Plan's benefit in advance. This will allow both the Participant and the Dentist to have, in advance, an estimate of what will be covered.

DENTAL LIMITATIONS & EXCLUSIONS

Dental Limitations

Benefit payments for a Participant in a Calendar Year will not exceed the Maximum Calendar Year Benefit Amount shown on the Schedule of Dental Benefits.

Many dental conditions can properly be treated in more than one way. In determining your benefit, the Plan will use the Regular, Reasonable and Customary Fees for the least expensive procedure that produces a professionally acceptable result.

Dental Exclusions

This plan does not cover loss caused by:

- Claims arising out of, caused by or contributed to war declared or undeclared, civil war, hostilities or invasion;
- Suicide, attempted suicide, or intentionally self-inflicted injury to the extent allowed by law;
- Service in the armed forces;
- Complications arising from excluded treatment;
- Commission of a felony or illegal activities.

Benefits will not be paid for:

- Any service or supply that a Participant is not legally required to pay for, including any forgiveness of payment by a provider;
- Any treatment of an Injury or Illness caused by or resulting from an Injury or that is recognized as a compensable loss by the provisions of any worker's compensation act, employer liability law, occupational disease law, or any similar law of a state government, federal government, or any other governmental subdivision, under which the person is or could be protected on a mandatory basis, whether or not such protection is afforded; or would have been recognized had the Participant made claim within the appropriate time limits. If the worker's compensation type coverage has denied a claim but the Participant is still pursuing coverage with the worker's compensation type coverage through a state or federal commission or agency, or other legal entity,

benefits will not be payable under this Plan until the Participant certifies he/she no longer intends to pursue coverage through the worker's compensation type coverage;

- Any service furnished by the Participant or member of his/her or his/her spouse's Immediate Family Member, or person who regularly lives in his/her home;
- Replacement of lost or stolen appliances;
- Any duplicate prosthetic device or dental appliance;
- Replacement of a damaged appliance, unless damaged while in the Participant's mouth in an Injury which occurred while covered under this Plan;
- Any treatment for damage caused by abrasion or attrition;
- Dietary or nutritional counseling;
- Education or training in personal oral hygiene or dental plaque control;
- Services or supplies which do not meet the accepted standards of dental practice;
- Treatment which is experimental/investigational in nature;
- Any drugs or medicines, except for injections of antibiotics and application of desensitizing medicines by the attending dentist;
- Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide, when charged by dentist on a separate basis from the procedure for which they are used;
- General anesthesia unless Medically Necessary and administered in connection with oral or dental surgery;
- Any services furnished for cosmetic reasons, including but not limited to facings on crowns or pontics on any teeth behind the second bicuspid;
- The replacement of a complete or partial denture within 5 years of the date of the last placement, unless replacement is required because of an Injury or additional extractions are required and the denture cannot be made useable;
- The replacement of any crown, inlay or onlay restoration, or fixed partial denture unless replacement is required because of an Injury;
- Services rendered before the Effective Date or after the Termination Date;
- Services to replace one or more teeth that were lost or services to complete dental work that was started before the Participant's Effective Date, except as provided for under the "If This Plan Replaces Another Plan" provision;
- Any services to replace one or more teeth that were lost before the Effective date, except as provided for under the "If This Plan Replaces Another Plan" provision;
- Orthodontic services;
- Any service or supply that is not listed as a Covered Expense.

ALTERNATE SERVICES

If two (2) or more services are considered to be acceptable to correct the same dental condition, the benefits payable will be based on the Covered Expenses for the least expensive service which will produce a professionally satisfactory result as determined by the Third Party Administrator.

If you or your Dentist decide on a more costly treatment than the Third Party Administrator has determined to be satisfactory for treatment of the condition, benefits will be limited to the lesser of the Maximum Allowable Fee charge and are subject to any deductible and coinsurance for the least costly treatment. The excess amount will not be paid by the Plan. The balance of the treatment charge remains the responsibility of the covered person.

FILING A CLAIM, CLAIM PROCEDURES, APPEAL PROCEDURES

The procedures outlined below must be followed by Participants to obtain payment of dental benefits under this Plan.

Claims

All claims and questions regarding health claims should be directed to the Third Party Administrator.

The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final Adverse Benefit Determination. If the Participant receives notice of a final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

  A "pre-service urgent care claim" is any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the Participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

    - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

    - The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service claims must be filed with the Third Party Administrator within 12 months of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days from receipt by the Participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Participant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:

    - If the Participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

    - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.

    - The Participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

- The Plan's receipt of the specified information; or
- The end of the period afforded the Participant to provide the information.

If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:
  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).
- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
  - Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

  - Notification to Participant 30 days

  - Notification of Adverse Benefit Determination on appeal 30 days

- Post-service Claims:

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15- day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will contain the following information:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's internal appeals and external review processes and the time limits applicable to the processes. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request;

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Participant believes the claim has been denied wrongly, the Participant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

- Participants at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- Participants the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

- For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a Participant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Participant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

- That a Participant will be provided, free of charge, and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Participant to respond to such new evidence or rationale.

Requirements for Appeal

The Participant must file the appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within [180] days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Participant chooses to orally appeal, the Participant may telephone:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

Group Plan Solutions Benefit Administration,
a Division of Pekin Insurance
2505 Court Street
Pekin, IL 61558
Phone: 888-301-0747
Fax: 309-478-2912
Email: inquiry@groupplansolutions.com
Website: www.groupplansolutions.com

It shall be the responsibility of the Participant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

- The name of the employee/Participant;
- The employee/Participant's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Participant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances; but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim; pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

- Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;

- A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

- A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

External Review Process

A. Scope

1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

2. The Federal external review process applies only to:

   (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

   (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

B. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not

required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Third Party Administrator to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

C. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit

Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Third Party Administrator's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

COORDINATION WITH MEDICARE AND MEDICAID

MEDICARE

When Medicare is primary payer, the Plan will coordinate the Plan benefits with Medicare in accordance with the "Coordination of Benefits" provision in this Plan.

If a covered person is eligible for Medicare as primary payer, but does not enroll or apply for it on time, the Plan will estimate what Medicare would have paid if the covered person had made timely application.

The Plan Administrator will determine if Medicare is primary payer based upon Medicare regulations and the status of the Participant on the date a covered expense is incurred.

MEDICAID

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Persons or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

COORDINATION OF BENEFITS

When the Plan is the secondary plan, the plan will determine the Regular, Reasonable, and Customary Charge. After the primary plan pays, the Plan will either pay what is left of the Regular, Reasonable and Customary Charge or the regular benefit, whichever is less. The Plan will not pay more than the Regular, Reasonable and Customary Charge amount. The secondary plan pays a reduced amount, which when added to the benefits paid by the primary plan, will normally equal 100% of the allowable expense. The benefits payable under the secondary plan cannot exceed the benefit that would be payable if there was no other group-type plan.

If an expense is eligible under both this Plan and a dental plan, this Plan will pay primary.

RULES FOR ORDER OF PAYMENT

The primary plan is:

- The plan which does not coordinate its benefits with any other plan.
- The plan which covers the person as an employee or student, rather than as a dependent. However, if a person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent, for example a retired employee.
- The plan of the parent whose birthday (excluding year of birth) occurs earlier in a calendar year, if both parents are living together. If both parents have the same birthday, the plan that has covered a parent the longest is primary. If the other plan does not have this provision in their Plan, then the plan which covers the father as an employee will be primary, rather than the plan which covers the mother as an employee.
- The plan of the parent with custody of the child, if the parents are divorced or separated. The secondary plan will be the plan of the spouse of the parent with custody. The final plan will be the plan of the parent without custody.
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, then the plan of the parent who has responsibility will be primary over the other parent or stepparent's plan. This provision does not apply until the Plan has been informed of the terms of the court decree. Any benefits paid prior to the Plans knowledge of the terms of the court decree will be subject to the other sections of this provision.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, then the plan of the parent whose birthday occurs earlier in the calendar year is primary.
- The plan which covers a person as an active employee, rather than the plan which covers the person as a laid-off or retired employee. The primary plan is the plan which covers the person as a dependent of an active employee, rather than the plan which covers the person as a dependent of a laid-off or retired employee.
- The plan which covers the person as an employee, or the dependent of an employee, rather than the plan which covers the person under any continuation coverage. If the other plan does not have a rule regarding continuation coverage, and as a result, the plans do not agree on which plan is primary, then this rule will be ignored.
- If none of the above rules apply, then the plan which has covered the Participant the longest is the primary plan. The length of time a person has been covered under a plan is measured from the claimant's first date of continuous coverage under the Plan.

REIMBURSING THE OTHER PLAN

If another plan has paid their benefit in error according to this provision, the Plan can make payment directly to them to satisfy the intent of this provision. Any payment made by the Plan for this reason will fully discharge the Plan Administrator of any liability under this plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under certain circumstances, you have the right to temporarily extend your dental coverage under this plan under a federal continuation provision called COBRA. COBRA continuation coverage is a continuation of dental coverage when coverage would otherwise end because of a life event known as a "qualifying event". After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your dependent children could become qualified beneficiaries if coverage under this plan is lost because of a qualifying event.

The dental coverage that will be extended is the same coverage that is provided to active covered employees.

Qualified beneficiaries who elect COBRA continuation coverage must pay the premiums for COBRA continuation coverage.

WHEN YOU BECOME A QUALIFIED BENEFICIARY

If you are a covered employee, you will become a qualified beneficiary if you lose your coverage under this plan because of one of the following qualifying events:

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

If you are the covered spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this plan because any of the following qualifying events happens:

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

A covered dependent child will become a qualified beneficiary if he/she loses coverage under this plan because any of the following qualifying events happens:

- The covered employee parent dies
- The covered employee parent's hours of employment are reduced
- The covered employee parent's employment ends for any reason other than his/her gross misconduct
- The covered employee parent becomes entitled to Medicare benefits under Part A, Part B, or both
- The parents become divorced or legally separated
- The child no longer meets the definition of a dependent child under this plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan Administrator, or the Plans designated representative, will notify you of your right to continue coverage under COBRA once the Plan has been notified that a qualifying event has occurred. The Plan Administrator will be aware when the qualifying event is end of employment or reduction of hours of employment, death of the employee.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For all other qualifying events, you must notify the Plan Administrator, or the Plan's designated representative, in writing of the qualifying event within 60 days after the event occurs. If the Plan Administrator, or the Plan's designated representative, is not notified within this time frame, COBRA continuation cannot be offered. In order to take advantage of the disability extension, you must also notify the Plan within sixty days of a determination by Social Security that you or a dependent are disabled. It is important for each covered person and covered dependent to timely provide the Employer with his current mailing address.

THE PLAN ADMINISTRATORS NOTIFICATION RESPONSIBILITIES

Once the Plan Administrators, or the Plans designated representative, receive notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA ELECTION PERIOD

You or your dependents have the responsibility to notify the Plan, or the Plan Administrator's designated representative, of your desire to continue coverage within sixty days from the later of the date of notification or loss of coverage. Upon acceptance, you or your dependent will be notified of any enrollment forms that must be completed. Qualified beneficiaries who elect continuation coverage are responsible for premiums back to the date termination from the Plan would have occurred.

If a covered person decides to continue this coverage, the first premium payment is due 45 days following the date he/she returns the election form. Coverage is provided only when the full premium for the applicable period is received. The covered person must pay any premiums after that within 30 days of the date the premium is due. Premium payments must be made to the Plan, or the Plan Administrators designated representative. Coverage is not in force for any period for which premium is not paid.

If you or a covered dependent experience a qualifying event and do not receive a qualifying event notification in a timely fashion, you should contact the Plan, or the Plan Administrator's designated representative, immediately.

LENGTH OF CONTINUATION

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled and you notify the Plan in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security Administration determination must be provided to the Plan Administrator within 60 days of the date of the determination and prior to the end of the 18th month of continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your covered spouse and covered dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have

caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

PERSONS WHO CANNOT CONTINUE

A covered person cannot continue this coverage under the COBRA continuation provision if:

- They are considered a spouse under the plan due to a state law that recognizes a same sex domestic partner as a spouse.
- At the time of his/her termination, the covered person is a nonresident alien with no earned income from sources within the United States, or is the dependent of such person.

COBRA TERMINATION

Although COBRA continuation coverage has a maximum time frame, you may voluntarily terminate coverage at any time by notifying the Plan, or the Plan Administrator designated representative, in advance. In addition, COBRA states that continuation coverage will end for one or more of the following reasons:

- The date the maximum continuation period has been exhausted
- The date the employer ceases to maintain any group dental plan for any employee
- The date the covered person is covered by another group dental plan which does not include a preexisting condition clause or which would have the preexisting condition limitation period reduced by qualifying previous coverage
- The date the covered person becomes covered by Medicare Part A and/or Part B
- The date any premium that is due is not paid within the time allowed.

A covered person's continuation under this Plan will terminate anytime this Plan is terminated.

GENERAL PROVISIONS

RIGHT TO RECOVERY

If the Plan made a payment in error, the Plan can recover the Plan's payment from another plan, the Participant, or anyone else to whom the Plan has made payment.

PAYMENT OF BENEFITS

All benefits under this Plan are payable to the covered employee whose illness or injury, or whose covered dependent's illness or injury, is the basis of a claim. In the event of the death or incapacity of a covered employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan, is or was providing the care and support of such Employee.

ASSIGNMENTS

Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received before the proof of loss is submitted.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

- In error;

- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
- Pursuant to a claim for which benefits are recoverable under any plan or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Plan Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Plan Participant shall be a trustee over those Plan assets.

In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured

parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Plan Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- any other source including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan Participant is also obligated to hold any and all funds so

received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

PLAN PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

1. Any Plan Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Plan Participant understands that he/she is required to:

    a) notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b) instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c) in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

EXCESS INSURANCE

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as

otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company; or
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

OBLIGATIONS

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
f) to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
g) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage;
h) to instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
i) in circumstances where the Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
j) to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Plan Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

MINOR STATUS

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services.

Plan Administrator

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with the plan provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator have maximum legal discretionary authority to:

- construe and interpret the terms and provisions of the Plan
- to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental/Investigational)
- to decide disputes which may arise relative to a Participant's rights, and
- to decide questions of Plan interpretation and those of fact relating to the Plan.

The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Participant is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

- to administer the Plan in accordance with its terms
- to determine all questions of eligibility, status and coverage under the Plan
- to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms
- to make factual findings
- to decide disputes which may arise relative to a participant's rights and/or availability of benefits
- to prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials
- to keep and maintain the Plan documents and all other records pertaining to the Plan
- to appoint and supervise a Third Party Administrator to pay claims
- to perform all necessary reporting as required by ERISA
- to establish and communicate procedures to determine whether a medical child support order is a QMCSO
- to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate, and
- to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents.

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and copies 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 copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Dental **Plan Coverage**

Continue health or dental care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan 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 your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Employee Benefits Security Administration.

HIPAA PRIVACY

Right to Receive and Release Information

The Third Party Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person which the Plan Administrator or Third Party Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, *et seq.*, or other applicable law, the Plan Administrator or Third Party Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Third Party Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, *et seq.*;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, *et seq*. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.