INDUSTRIAL HEAT TRANSFER, INC.

GROUP DENTAL BENEFITS

Effective June 1, 2014

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SUMMARY OF DENTAL BENEFITS INDUSTRIAL HEAT TRANSFER	
Annual Maximum	$1,200
Deductible	$0 Deductible
Preventative Services	Payable at 100% not subject to Deductible
Preventative Includes:	Routine exams and cleanings – once every 6 months Bitewing x-rays – 4 films every 6 months Full mouth or panoramic x-rays – once every 3 years Fluoride treatments for Dependents under age 19, every 6 months Space maintainers – for Dependents under age 14 Single x-rays
Basic Services	Payable at 80% after deductible
Basic Includes:	Emergency exams and treatment for pain relief Fillings Stainless steel or resin crowns for Dependents under age 14 Restoration of diseased or broken teeth Extractions Oral surgery Periodontic procedures Endodontic procedures
Major Services	Payable at 50% after deductible
Major Includes:	Crowns, inlays and onlays Dentures and bridges Implants
Pre-authorization of services is recommended for courses of treatment exceeding $500.00. All payments are subject to usual and customary reductions. This plan will pay as secondary on any procedures that are eligible through the patient's medical plan.	

The above lists of services are not intended to be all inclusive. Please check the plan document for more detailed information.

1. DEFINITIONS

***Active Employee**:* Active Employee means a person the Employer classifies as a W2 and has begun to perform the duties of his or her job on a full-time basis.

***ADA**:* ADA means the American Dental Association

***Administrative Services Manager**:* The Administrative Services Manager is 3PAdministrators.

Appliance: Appliance means any dental device other than a Prosthetic Device.

***Calendar Year**:* Calendar year means January 1 through December 31.

Child: Child means any of the following:

1. Your natural child under the age of 26 including any child for whom You are required to provide coverage under a Qualified Medical Child Support Order;
2. A child who, before reaching age 18, was either adopted by You or placed in Your home for adoption;
3. Your child of any age who because of a physical or mental disability is incapable of sustaining his or her own financial support or independent living, if the disability began before the child attained age 26 and while covered under this Plan. Coverage may continue for as long as the child remains disabled, unmarried and wholly dependent on You for financial support (consistent with the Internal Revenue Code). The Plan may require You at any time to submit a physician's statement certifying the child's physical or mental disability;
4. Your stepchild who is dependent on You for his/her principal support and maintenance and maintains residence with You; and
5. A foster child if he or she lives with You and who is dependent on You for his/her principal support and maintenance.

***COBRA**:* COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry: Cosmetic Dentistry means service performed to approve appearance without any dentally necessary reason.

***Covered Expense**:* Covered Expense is the necessary services covered under the Plan.

***Covered Person**:* Covered Person is an Eligible Employee or Dependent who is covered under the Plan.

***Deductible**:* Deductible means the amount of Covered Expenses that must be paid by a Covered Person before the Plan will begin reimbursement of additional Covered Expenses incurred by the Covered Person.

Dentist: Dentist means any dental or medical practitioner the law requires the Plan to recognize whom: Is properly licensed or certified under the laws of the state where he practices; and provides services that are within the scope of his license or certificate and covered by this Plan.

Dependent: Dependent means one or more of the following person(s) as defined herein:

1. A Spouse of an Employee;
2. A Child of an Employee; or

3. A grandchild of an Employee provided that the parent of the Child is a covered Dependent and is under 18 years of age.

Employee: Employee is an active, regular Employee of the Employer, regularly scheduled to work at least 30 hours per week, 48 weeks per year.

Employer*:* Employer means Industrial Heat Transfer.

ERISA*:* ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational*:* Experimental or Investigational is any service, supply, care and/or treatment that does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community.

Injury*:* Injury is an accidental physical Injury to the body caused by unexpected external means.

Late Enrollee*:* A Late Enrollee is anyone who enrolls under the Plan other than during the first 30 day period that the individual is eligible to enroll or during a Special Enrollment Period.

Lifetime: Lifetime is the period of time that an individual is enrolled in the Plan. Under no circumstances does Lifetime mean the lifetime of the individual.

Medically or Dentally Necessary*:* Necessary care is treatment recommended or approved by a Dentist that is consistent with the patient's condition and is accepted practice in the dental community. The treatment is proven to be effective and is not performed for the convenience of the patient or Dentist. Care is not conducted for research and is determined to be the most appropriate level of care for the condition and the patient. Because a Dentist or Physician recommends or approves a treatment, that does not mean it is Medically or Dentally Necessary.

Open Enrollment Period: Each December there will be an Open Enrollment Period when Eligible Employees not currently on the Plan are allowed to join the Plan. Enrollment forms must be submitted by December 31st to be eligible for coverage effective January 1st. Covered Persons may also make changes during the Open Enrollment Period by adding or dropping Dependents.

Plan*:* The Plan means the Industrial Heat Transfer Employee Dental Welfare Benefit Plan.

Plan Participant: A Plan Participant is an Employee or Dependent covered under the Plan who has met the eligibility requirements and has submitted an enrollment application within the time period specified. See Section 7 Eligibility for more information.

Plan Year*:* Plan Year is the 12 month period beginning on the effective date of the Plan.

Predetermination: Predetermination is a review by the Plan of a Qualified Practitioner's plan of treatment and expected charges. The Plan will estimate what it expects to pay based on the benefits available when the Predetermination is received.

Prosthetic Device: Prosthetic Device means a device that is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, poetics and cast restorations.

Reasonable: The Plan will only pay fee(s) that, in the administrator's discretion, are for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) The Food and Drug Administration; and (c) the American Dental Association. To be Reasonable, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for fee(s) to be considered not Reasonable.

Special Enrollee: A Special Enrollee is an eligible Employee or eligible dependent who is entitled to and who requests Special Enrollment (as described in Section 3):

1. Within 30 days of losing other health coverage; or
2. For newly acquired Spouse or Child, within 30 days of the marriage, birth, adoption or placement for adoption

Spouse: Spouse means an individual who is legally married to an Employee as determined under applicable state law (and who is treated as a spouse under the Internal Revenue Code). Spouse also includes a common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has principal residence.

Usual and Customary: Only Usual and Customary charges are covered expenses. When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply and the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, with "area" meaning a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers rendering such service or furnishing such supplies.

The term "usual" refers to the amount of a charge made for services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other professionals with similar credentials which are located in the same geographic locale in which the charge is incurred.

The term "customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "same geographic locale" and/or "area" means a city, county, or such greater area as may be necessary to establish a representative cross section of persons or organizations regularly furnishing the type of treatment, services, or supplies for which a specific charge is made.

The term “usual and customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, The Plan Administrator will determine what the usual charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Waiting Period*:* Waiting Period means the period before an eligible Employee may become covered under this Plan. Coverage begins on the first of the month following the date of hire.

You and Your: You and Your refers to an eligible covered Employee, or where appropriate in context and unless otherwise indicated.

2. OUTLINE OF DENTAL BENEFITS

Plan Maximums:	$1,200 per Covered Person per Calendar Year for a combined total of Class A, B and C services
Deductible:	$0 – there is no Deductible for dental services

Coinsurance

Class A (Preventive) Services	100% (You pay 0%)
Class B (Basic) Services	80% (You pay 10%)
Class C (Major) Services	50% (You pay 40%)

Each Calendar Year, the Plan will pay the applicable percentage shown for Covered Expenses, subject to Plan maximums and Usual and Customary reductions.

Refer to the **Dental Covered Expense** section and the **Exclusions and Limitations** sections for additional information.

3. PLAN INFORMATION - DENTAL

Pretreatment Review - When the expected cost of a proposed course of treatment is $500.00 or more, You must send a treatment plan in an acceptable format to 3PA for approval before treatment starts. The treatment plan must include:

a) A list of the services to be done, using the American Dental Association Nomenclature and codes;
b) The itemized cost of each service; and
c) The estimated length of treatment.

You must also provide dental x-rays, study models and whatever else the Plan requests to evaluate the treatment plan. The Plan will review the treatment plan and estimate what it will pay. The Plan will send the estimate to the Covered Person and the Covered Person's Dentist. If the Plan does not agree with a treatment plan, or if one is not sent in, the Plan will base its payments on treatment the Plan determines is suited to the Covered Person's condition based on accepted standards of dental practice. Pre-treatment review is not a guarantee of what the Plan will pay. The

estimate states in advance to the Covered Person and his Dentist what the Plan will pay for the covered dental services delineated in the treatment plan. However, payment is conditioned on:

- The work being done as proposed and while the Covered Person is insured; and
- The deductible and payment limit provisions and all of the other terms of this Plan.

Emergency treatment, oral examinations, dental X-rays and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

Integration with Medical Benefits. - In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered as a dental expense only if the amount normally paid under the dental provision exceeds the amount paid under the medical provision, and only up to the excess amount.

Expenses are Incurred - An expense is incurred when the service is performed, except that it is deemed to be incurred:

a) When preparation of the tooth is begun for a crown;
b) When the final impressions are taken for dentures or fixed bridgework; and
c) When the pulp chamber is opened for root canal treatment.

No benefits will be paid for any type of work not listed above that is completed after coverage under this Plan ends.

If this Plan Replaces Another Plan. - This Plan may be replacing another plan the Employer maintained. If so, this Plan starts immediately after the prior plan ends and will pay for certain charges incurred for a Covered Person before this Plan starts, if:

a) The Covered Person is covered under this Plan on the date it begins,
b) The Covered Person was covered under the prior plan on the date the prior plan terminated, and
c) The prior plan would have paid such charges. The Plan will pay the lesser of:
    i. What the old plan would have paid; or
    ii. What we would otherwise pay.

This Plan will deduct any benefits actually paid by the old plan under any extension provision from benefits paid under this Plan.

4. LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. Any procedure not listed is excluded. All covered dental services must be furnished by or under the direct supervision of a Dentist. They must be usual and necessary treatment for a dental condition. The Plan will reimburse the service provider directly for eligible expenses unless You submit a receipt.

Preventive Dental Services:

Routine oral examinations are limited to one exam every 6 months.

Prophylaxis (cleaning) is limited to once every 6 months.

Topical fluoride treatment for Your Eligible Child under the age of 19 and limited to one treatment every 6 months. A prophylaxis performed in conjunction with a fluoride treatment is a separate dental service.

Full mouth series or panoramic x-rays are limited to once every 36 months.

Bitewing x-rays are limited to 4 films every 6 months.

Periapical and occlusal x-rays.

Extraoral x-rays are limited to one (1) film per six month period.

Space maintainers for Your Eligible child under the age of 14 and limited to the initial Appliance only.

Basic Services:

Emergency palliative treatment and other non-routine, unscheduled visits. This is covered only if no other service (except x-rays) is rendered during the visit.

Restorative Services:

(a) Sealants: for Your Eligible child under the age of 14. Limited to molar teeth and not more than one per tooth per Lifetime. Sealants on primary teeth are not covered.
(b) Fillings: amalgam, acrylic and synthetic. Posterior resins are payable at the amalgam rate.
(c) Crowns: stainless steel, limited to Dependent children under age 14 with one stainless steel crown per tooth in 36 months

Diagnostic Services:

(a) Diagnostic casts.
(b) Biopsy and examination of oral tissue.

Endodontic Services:

(a) Root canal treatment, including x-rays and cultures.
(b) Pulp capping.
(c) Vital pulpotomy.
(d) Apexification.
(e) Apicoectomy.
(f) Hemisection.

Periodontic Services.

(a) Root planning.
(b) Occlusal adjustment when done in conjunction with periodontal surgery.
(c) Periodontal Appliance.
(d) Gingival curettage.
(e) Mucogingival surgery.
(f) Osseous surgery, once per quadrant per Benefit Year,
(g) Osseous graft.
(h) Gingivectomy.

Periodontal splinting is not a Covered Expense.

Oral Surgery. Extractions and other oral surgeries. General anesthesia in connection with covered oral surgery only.

General Anesthesia, upon demonstration of medical necessity.

Local anesthesia and analgesia when administered in conjunction with a covered procedure.

Injections of antibiotic drugs by the Dentist.

Sedative fillings only when no other service is rendered to the same tooth during the same visit, except for an x-ray.

Major Services:

Restorative Services:

(a) Crowns.
(b) Inlays.
(c) Onlays.
(d) Crowns and posts.
(e) Porcelain veneers on crowns. Not allowed on posterior teeth.

The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic are only eligible when the teeth must be restored with gold.

Prosthodontic Services.

(a) Fixed bridges.
(b) Full or partial dentures.
(c) Implants.

Initial installation of, or addition to, full or partial dentures or fixed bridgework. Dentures and bridgework will be considered to be initially installed only if the dentures or bridgework do not replace existing dentures or bridgework. Such denture or bridgework includes the replacement of any extracted teeth and must be completed within 12 months of when the work is started. There is coverage for replacement or alteration of full or partial dentures or fixed bridgework if You have been covered under the Plan for at least 2 consecutive years and if it has been at least 5 years since the last installation. Such expenses must have occurred on or after the effective date of coverage and must be completed within 12 months. Replacements must be Dentally Necessary and due to:

Placement of an opposing full denture;
Extraction of additional teeth;
Injury that damaged the bridge or denture beyond repair; or
Replacement of a temporary denture placed while You were covered under this Plan.

Repair of crowns and bridgework.

Major services must be performed on permanent teeth to be considered for payment.

Denture rebase limited to once in 3 years.

Denture reline limited to once in 3 years and not within the first 12 months after the initial insertion.

5. SPECIAL LIMITATIONS – DENTAL

Alternate Treatment. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit

payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

Teeth Lost Before A Covered Person Became Covered under this Plan. This Plan will not pay for charges or services for a Prosthetic Device that replaces one or more teeth lost before a Covered Person became covered under this Plan if You declined to enroll when You were initially eligible to enroll.

If this Plan Replaces Another Plan. If this Plan replaces another plan the Employer maintained, this Plan will pay for certain charges incurred before this Plan became effective if the person who incurred the expense was covered at that time under the prior Employer plan and the prior Employer plan would have paid the expense. In such circumstances, the Plan will limit the amount it will pay to the lesser of what would have been paid under the prior Employer plan or what would be paid under this Plan after deducting any benefits paid for such expenses under the prior Employer plan.

6. EXCLUSIONS AND LIMITATIONS – DENTAL

No payment will be eligible under any portion of this Plan for Dental Expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited under this Plan, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits. Any such payment does not waive the written exclusions, limitations or other terms of the Plan.

This plan does not provide dental benefits for:

Expenses incurred prior to the effective date of coverage, or after the termination date of coverage.

Services or supplies

a) For which no charge is made, or for which You would not be legally obligated to pay if You did not have coverage under this Plan.
b) Furnished or payable under any plan or law through any government or any political subdivision (this does not include Medicare or Medicaid).
c) Furnished in the treatment of any service-related Injury or Sickness (past or present) while You were confined in a Hospital or institution owned or operated by the United States Government or any of its agencies.

Expenses which do not meet the standards of dental practices accepted by the American Dental Association, or for services not prescribed as necessary by a Physician or Dentist.

For any Injury or Sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain.

For any Injury or Sickness for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, employer liability law, or any similar law, regardless of whether a claim was filed for such benefits.

Paid, or payable under any medical payment, personal injury protection, automobile, or other coverage that is payable without regard to fault.

Furnished while the Covered Person was not under the regular care of Qualified Practitioner;

Not authorized or prescribed by a Qualified Practitioner.

Any loss to a Covered Person who is not a member of the armed forces which was caused or contributed to by:

a) War or any act of war, whether declared or not, or
b) Any act of international armed conflict, or
c) Any conflict involving armed forces or any international authority.

Completion of forms or failure to keep an appointment with the Dentist, or telephone or email consultations.

Additional charges for services after normal provider business hours or holidays.

Replacement or lost, missing, broken or stolen appliances or duplicate appliances.

Cosmetic Dentistry, including personalization or characterization of dentures and facing on crowns, abutments or pontics posterior to the second bicuspid, or labial veneer laminates.

Nitrous oxide analgesia.

Prescription drugs.

Hospital expenses or for services of any anesthesiologist.

Expenses for installation, replacement or alteration of, or addition to, dentures and fixed bridgework, except as specified in Dental Covered Expenses.

Expenses for the surgical or non-surgical treatment of temporomandibular joint dysfunction.

Expenses for mouth guards, night guards, or take home items.

Expenses for preventive control program including oral hygiene, plaque control, dietary planning, or other educational programs, lab tests, anaerobic culture except in connection with periodontal disease, sensitivity training and bite registration.

Expenses for a temporary full Prosthetic Device or for adjustment or relining of a Prosthetic Device within the first 6 months after the Prosthetic Device is initially furnished.

Expenses for treatment by other than a Dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist under the supervision and direction of a Dentist consistent with generally accepted dental standards.

Treatment by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister.

Appliances or restorations for: increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correction or congenital malformation.

Precision or semi-precision attachments.

Dental services which do not have uniform professional endorsement.

Expenses for procedures or restorations other than those listed in the Dental Covered Expenses section.

For expenses where there are alternate courses of treatment available carrying different fees, the Plan will provide benefits only for the treatment carrying the lesser fee.

Periodontal splinting.

Expenses in excess of the Customary, Usual and Reasonable charges.

Care and treatment for which there would not have been a charge if no coverage were in force.

Charges excluded or limited by the Plan as stated in this document.

This list is not meant to be exhaustive. Please contact the Administrative Services Manager for questions about your benefits.

7. ELIGIBILITY

An Employee is eligible to participate in this Plan if You are within one of the following categories of Employees:

a) Employees who were eligible and covered under any group plan this Plan replaces will be eligible on the Effective Date of this Plan. Any Waiting Period or portion of a Waiting Period satisfied under the prior plan will be applied toward satisfaction of the Waiting Period under this Plan.

b) Employees who have completed a Waiting Period with the Employer while classified by the Employer as a Full-time Employee. An Employee will be considered Full-time if regularly scheduled to work at least 30 hours per week, 48 weeks per year and is on the regular payroll of the Employer for that work.

Your eligibility date is the date You satisfy the above conditions. Coverage becomes effective the first of the month following Your date of hire as a Full-time Employee.

In no event can a person receive coverage both as an Employee and as a dependent of another Employee. For example, You may not have coverage for yourself as an Employee and be a dependent on the coverage of Your Spouse who has family coverage as an Employee.

Dependent Eligibility. Your eligible dependents may participate in this Plan if You are concurrently a participant. "Eligible Dependents" include any of the following:

(a) Your Spouse.

(b) Your Child.

(c) Your grandchild as long as the child's parent is a covered Dependent of the Employee and is under 18 years of age.

Dependents do not include the children of your domestic partner unless they are your legal dependents as well. Dependents also do not include parents or any other relatives not listed previously.

If You and Your Spouse are both Employees, either one of You, but not both may cover Your eligible Dependents. This also applies to two divorced, legally separated, or unmarried Employees who share legal responsibility for any dependent Child.

Eligible Dependents

(a) Your newborn Child or newly adopted Child will be eligible from the moment of birth or placement for adoption if You properly file the appropriate enrollment form for the Child with the Plan Administrator within thirty (30) days of the Child's date of birth or placement for adoption. Included is Your grandchild whose parent is Your covered Dependent under age 18.

(b) Your Spouse will be an eligible dependent from the date of marriage if You properly file the appropriate enrollment form for Your Spouse with the Plan Administrator within thirty (30) days of the date of marriage.

(c) Your Dependent You acquire other than at birth, due to a court order or decree of marriage will be eligible from the date of such court order, decree or marriage if You properly file the appropriate enrollment form with the Plan Administrator within thirty (30) days of the date of the order, decree or marriage.

(d) Your Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to eligibility and the effective date provisions contained in the "Qualified Medical Child Support Order".

Your eligible Dependents may participate in this Plan only if You are concurrently a participant.

Effective Date of Coverage. Coverage under this Plan for You and Your eligible Dependents if You have enrolled on forms furnished and accepted by the Plan Administrator, will begin at 12:01 a.m. on the following date ("Effective Date") if you are Active-at Work:

a) The initial date of coverage is the first of the month on or You satisfy a Waiting Period with the Employer as a full-time Employee. Employee must be Actively-at-Work on the effective date of coverage, or coverage for You and Your eligible dependents will be delayed until the first day of the payroll period following the date Employee returns to active payroll status as a full-time Employee. Your coverage will not be delayed, however, if you are not Actively-at-Work on the initial effective date of coverage due to your health status, medical conditions, or disability, or that of your Dependent, as defined in Section 902(a) of the Internal Revenue Code.

b) Coverage for Your newly acquired Dependents will become effective for those Dependents on their eligibility date or the first day of the month following the date the Plan Administrator receives Your completed application for coverage. A newborn Child, an adopted Child or a Child placed for adoption can only be added on the date of birth, adoption or placement for adoption. You may choose to delay enrollment of a newborn Child until the Child reaches age three (3). An appropriate enrollment form for the Child must be submitted within thirty (30) days after the Child's third birthday.

c) Coverage for Your Dependent acquired through a Qualified Medical Child Support Order, a National Medical Support Notice or a Medical Child Support Order will be subject to eligibility and the effective date provisions contained in the "Qualified Medical Child Support Order".

d) Dental coverage for Your Dependent, if provided under the Plan, will be effective on the first of the month following the date the Plan

Administrator receives Your enrollment forms, but benefits will be limited during Your first 12 months of coverage.

Coverage for Your eligible dependent will not be effective in any case prior to the effective date of Your coverage.

In all cases, You must file your enrollment for coverage under the Plan with the Plan Administrator within 30 days of the event permitting enrollment. You must use the enrollment form designated by the Plan Administrator and your enrollment form must include the following information: name, date of birth, gender, Social Security number, and relationship to the employee. If the Plan Administrator receives Your completed enrollment forms **more than thirty (30) days after** Your eligibility date or the eligibility date for Your Dependent, respectively, You or the Dependent, as applicable, will be a **Late Enrollee** and coverage will be effective the first of the month following the date the enrollment form is received.

If Your Dependent Child becomes an eligible Employee of the Employer, the Child is no longer eligible as Your Dependent and must apply for coverage as an eligible Employee. Refer to "Qualified Change in Family Status –Special Enrollment" in this section for more information.

Initial Enrollment. You must complete Your enrollment for You and any eligible Dependents **within 30 days of the date** the eligibility requirements are satisfied. If You fail to enroll within 30 days of the date You meet the eligibility requirements, You and any of Your eligible Dependents will each be a Late Enrollee. Coverage for a Late Enrollee will be effective the first of the month following the date the enrollment form is received. Your next opportunity to enroll will be during either the Open Enrollment period or a Special Enrollment period, if You are an eligible Employee at that time.

You must complete enrollment for a newly acquired eligible dependent within 30 days of the date You first acquire the eligible dependent (e.g. marriage). Failure to enroll Your newly acquired eligible Dependent within 30 days will result in Your newly acquired eligible Dependent being a Late Enrollee with coverage effective the first of the month following the date the enrollment form is received.

Termination of Coverage. Coverage will terminate on the earliest of:

a) The date the Plan is terminated;
b) The last day of the month in which the covered Employee ceases to be in an eligible class of Employees; or
c) The end of the period for which the required contribution has been paid.

For Dependents, coverage terms:

a) The date the Plan or Dependent coverage under the Plan is terminated;
b) The date the Employee's coverage terminates;
c) The date a covered Spouse loses dependency status;
d) The last day of the month in which a Dependent no longer satisfies the definition of an eligible Dependent.

Reinstatement of Coverage. If your coverage ends due to employment termination, during a period of lay-off or after an approved leave of absence and You are now returning to work, the Employee who is rehired will be treated as a new Employee subject to the Waiting Period and all eligibility requirements. If the Employee was covered under COBRA continuation and that coverage is still active at the time of rehire, no Waiting Period will apply.

Special Enrollment. The Plan will provide a special enrollment period during which You or Your eligible dependents may enroll in this Plan. You may enroll in coverage, waive coverage and add or drop eligible dependents from Your coverage if a Special Enrollment change is experienced.

If You experience a Special Enrollment change but fail to enroll within the amount of time specified in the following sections, You will lose the ability to make an enrollment change. In that event, You will not be able to make any changes until the next Special Enrollment. Please take note of the periods allowed for You to make midyear enrollment changes. You may add coverage for all eligible Dependents within 30 calendar days of the following events:

a) You legally marry.
b) If Your Spouse loses group coverage, You may add family coverage. Loss of coverage includes any change in coverage that results in termination of Your Spouse's coverage, even if it is immediately replaced by other subsidized coverage. You must provide a statement from the former plan administrator documenting the loss of coverage.
c) When You acquire a dependent Child. In addition, at this time You can add your Spouse who has not been covered under this Plan.
d) When Your unmarried dependent Child from age 19 to age 25 meets the eligibility criteria.

Loss of coverage does not include the following:

a) A change in service providers of the plan or the plan administrator but where the coverage is continuous and uninterrupted;
b) A change in your eligible dependent's plan benefit levels; or
c) A voluntary termination of coverage by Your dependent, including, but not limited to termination or reduction of coverage due to the adoption of cafeteria-style plans.

8. HOW TO SUBMIT A CLAIM

You or the provider must submit claims to the address shown on Your ID card. 3PA does not require a special form to submit claims. You must, however, submit claims in a format acceptable to 3PA and comply with any applicable legal requirements. The Plan will not accept submitted claims that do not comply with the requirements of applicable Federal law respecting privacy of protected health information and/or electronic claims standards.

You must submit claims directly to 3PA at the address shown below if the provider who provided the services does not file the claim. You may submit your written claim to 3PAdministrators by mail (postage prepaid), by fax or by e-mail as indicated below:

Attention: Claim Department
3PAdministrators
PO Box 247
Onalaska, WI 54650

Phone: 608-779-3000 or 888-540-0094
Fax: 608-779-3009 or 877-540-0094
Email info@3pa.com

You must include the following information for claims you submit:

- The date of service;

- The name, address, telephone number and tax identification number of the provider of services or supplies;
- The place where the services were rendered;
- Procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the Covered Employee; and
- The name of the patient

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. Payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a 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, if any, under the Plan.

Each Covered Person claiming benefits under the Plan will 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 determines that the Covered Person has not Incurred a Covered Expense or coverage is not available under the Plan, or if the Covered Person fails to furnish such proof as is requested, no benefits will be payable under the Plan.

Time Limit in Which to File a Claim. You must file a written claim for benefits with the Plan within 90 days after the claim was Incurred. Your claim will not be denied if the Plan Administrator determines it was not reasonably possible for you to file such proof of claim within 90 days. The latest you may file a claim with the Plan is 12 months after the date the claim was Incurred, except in the case of legal incapacity.

If the Employer terminates this Plan, you must file written claims for services incurred prior to the termination date with the Plan Administrator within 90 days of the Plan termination date. Any claim received by the Plan Administrator more than 90 days after this Plan is terminated will not be a Covered Expense.

Payment of Claims. You or the provider must direct all claims and questions regarding health claims to 3PA. The Plan Administrator will 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 provisions of the Plan and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to 3PA; provided, however, that 3PA is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Assignment. The Plan will make direct payment to the provider of service, or such other person determined by the Plan Administrator to be the appropriate recipient. Such claim must contain adequate documentation of the prior payment, and the payment will discharge the Plan from any further liability with respect to the claim.

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to You, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. The Plan Administrator will pay benefits which have been assigned directly to the assignee unless the Plan Administrator receives a written request not to honor the assignment, signed by the covered Employee and the assignee before receiving the claim for expenses from the assignee.

9. CLAIM PROCEDURES

You are entitled to file a request for review if the Plan determines that services for You or a Covered Person will not be covered under the Plan, in whole or part, due to an eligibility, enrollment, or other administrative issue, or due to a claim that has not been pre-authorized, or if the Plan wholly or partially denies a claim for benefit payments. You must follow the procedures in this section to request a review of a claim.

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. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

Claims Administrator Review and Appeals Process.
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 medical care. However, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person 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.

A "Pre-service Urgent Care Claim" is any claim for medical 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 Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if You need medical care for a condition which could seriously jeopardize Your life, there is no need to contact the Plan for prior approval. You should obtain such care without delay.

The Plan **does not require** the Covered Person to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Covered Person 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.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants inpatient Confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated 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 determines that the course of treatment should be reduced or terminated; or
- The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require a covered Person 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. Simply follow 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.

Time of Claim Determination. The Covered Person will be notified of an adverse benefit determination consistent with this section (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 Non-urgent Care Claims:

If the Covered Person has provided all of the information, in the Plan's discretion, 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 Covered Person has not provided all of the information needed to process the claim, then the Administrative Service Manager will notify the Covered Person of what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Plan will notify the Covered Person 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 Covered Person (if additional information was requested during the extension period).

Concurrent Claims:

a) Plan Notice of Reduction or Termination. If the Plan Administrator is notifying a Covered Person 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 Covered Person will be notified sufficiently in advance of the reduction or termination to allow an appeal and to obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

b) Request by a Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person 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 24 hours after receipt of the claim, as long as the Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person 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.

c) Request by a Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the Plan will treat that request 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).

Post-service Claims:
If a Covered Person 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 a Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, the Plan will notify the Covered Person of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, the Covered Person You will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

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 You, 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 You, 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 will 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 will provide You with a notice of an adverse benefit determination, either in writing or electronically. The notice of adverse benefit determination will contain the following information:

- A reference to the specific portion(s) of the Plan Document upon which a denial is based;
- Specific reason(s) for the denial;
- A description of any additional information necessary for You to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of Your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the Covered Person 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 claim for benefits;

- The identity of any medical or vocational experts consulted in connection with the 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 in making the determination (or a statement that it was relied upon and that a copy will be provided to You, free of charge, upon request); and
- 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 Your medical circumstances, or a statement that such explanation will be provided to You, free of charge, upon request.

Appeal of Adverse Determinations.

Full and Fair Review of All Claims

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

- at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- 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 will be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- a review that takes into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the 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 will 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;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; and
- that the Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits in possession of the Plan Administrator or the Administrative Services Manager; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances.

Requirements for Appeal

You must file an appeal of a post-service claim in writing within 180 days following receipt of the notice of an adverse benefit determination. The Covered Person must send a written appeal to the Plan addressed as follows:

For Pre-service and Post-service Claims:
3PAdministrators
Attn: Claim Appeal Department
P.O. Box 247
Onalaska, WI 54650

The Covered Person is responsible for submitting 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;
- The Employee'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 be waived. In other words, You and/or the Covered Person will lose the right to raise factual arguments and theories which support this claim if You fail 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 You have which indicates that You are entitled to benefits under the Plan.

If the Covered Person provides all of the required information to the Plan, the Plan may determine that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator will notify the Covered Person of the Plan's benefit determination on review within the following time frames:

a) *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.
b) *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.
c) *Post-service Claims*: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
d) *Calculating Time Periods*: The period of time within which the Plan's determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator will notify the Covered Person, in writing or electronically, of a Plan's adverse benefit determination on review, stating:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the Plan Document on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

- A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to You upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, will be provided free of charge upon request;
- A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; 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 will 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 to be Final
The Covered Person may consider the Plan has denied the claim if, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set above. 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 given the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

10. COORDINATION OF BENEFITS

Benefits described in this Plan are coordinated with benefits provided by other plans under which the Covered Person is covered. This section applies when the Covered Person has health care coverage under more than one plan, as defined below. Benefits will be reduced under certain circumstances when the Covered Person is covered both under this Plan and any other plan defined below which also provide coverage for Covered Expenses. Reimbursement under this Plan and any other plans included under this provision will not exceed 100% of the total Allowable Expenses Incurred under this Plan. Benefits under this Plan will be coordinated with benefits paid or payable under another plan, as defined, whether or not a claim is filed with such other plan.

Definition of Other Plans. For purposes of this section this Plan will coordinate benefits with other plans providing any coverage which includes reimbursement of medical or dental expenses, or provides benefits or services by:

a) Group or franchise insurance coverage, whether insured or self-insured;

b) Hospital or medical service organizations on a group basis and other group pre-payment plans;
c) A licensed Health Maintenance Organization (HMO);
d) Any coverage sponsored or provided by or through an educational institution;
e) Any governmental program or a program mandated by state statute;
f) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle Accident, and any other medical and liability benefits received under any automobile policy; or
g) Any coverage sponsored or provided by or through an employer, trustee, union, employee benefit, or other association. This includes group-type contracts not available to the general public, obtained and maintained only because of the Covered Person's membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion.

How Coordination of Benefits Works. One of the plans involved will pay benefits first, without considering the benefits available under the other plans. This is called the "primary plan". The other plans will then make up the difference, up to the total Allowable Expense. Primary plan/secondary plan" is determined by the Order of Benefits Rules. When this Plan is a primary plan, its benefits are determined before any other plan and without considering the other plan's benefits. When this Plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When you are covered under more than two plans, this Plan may be a primary plan to some plans and may be a secondary plan to other plans.

When a plan provides benefits in the form of services rather than cash payments, the Customary, Usual and Reasonable cash value of each service will be deemed to be both a Covered Expense and a benefit paid. This Plan will not pay more than it would have paid without this provision.

Allowable Expenses. Allowable Expenses means any Medically Necessary, Customary, Usual and Reasonable item of expense, at least a portion of which is covered under this Plan. Benefits payable under any other plan include the benefits that would have been payable had a claim been properly made. In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider. "Allowable expense" does not include:

a) an item or expense that exceeds benefits that are limited by statute or this Plan; or
b) the difference between the cost of a private and a semi-private hospital room, unless admission to a private hospital room is Medically Necessary under generally accepted medical practice or as defined under this Plan.

Order of Benefits Determination Rules. A plan will be the primary plan and pay benefits first if it meets one of the following conditions:

a) The plan has no coordination provision;
b) The plan covers the person as a Employee;

c) The plan covering a laid off or retired person, or a person on COBRA or any other form of continuation, will pay benefits after the plan covering such persons as an active Employee.

d) The plan covering the person under a disability extension of benefits will pay benefits before the plan covering such persons as an active Employee.

Dependent child of parents not separated or divorced. When this Plan and another plan cover the same child as a dependent of different persons, called "parents":

a) the plan that covers the parent whose birthday falls earlier in the year determines benefits before the plan that covers the parent whose birthday falls later in the year; but

b) if both parents have the same birthday, the plan that has covered the parent longer determines benefits before the plan that has covered the other parent for a shorter period of time. However, if the other plan does not have this rule for children of married parents/registered same-sex domestic partners, and instead has a rule based on the gender of the parent, and, if as a result the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

Dependent child of parents divorced or separated. If two or more plans cover a dependent child of divorced or separated parents, the plan determines benefits in this order:

a) first, the plan of the parent with custody of the child;

b) then, the plan that covers the spouse of the parent with custody of the child;

c) finally, the plan that covers the parent not having custody of the child.

However, if the court decree requires one of the parents to be responsible for the health care expenses of the child, and the plan that covers that parent has actual knowledge of that requirement, that plan determines benefits first. This does not apply to any claim determination period or plan year during which any benefits are actually paid or provided before the plan has that actual knowledge.

If the above rules do not apply or cannot be determined, then the Plan that covered the person for the longer period of time will be primary.

Effect on Benefits of This Plan. When Order of Benefits Determination Rules requires this Plan to be a secondary plan, this section applies. Benefits of this Plan will be reduced when the sum of: a) the benefits payable for allowable expenses under this Plan, without applying coordination of benefits, and b) the benefits payable for allowable expenses under the other plans, without applying coordination of benefits or a similar provision, whether or not claim is made exceeds those allowable expenses in a claim determination period. "Claim determination period" means a Plan Year, except any part of a year the person is not covered under this Plan, or any part of a year before the date this section takes effect. In that case, the benefits of the medical portion of this Plan are reduced so that benefits payable under all plans do not exceed allowable expenses. For the prescription drug portion, benefits payable under this Plan are reduced so that benefits do not exceed allowable expenses less any prescription co-pays. When benefits of this plan are reduced, each benefit is reduced in proportion and charged against any applicable benefit limit of this Plan.

Right to Receive and Release Needed Information. Certain facts are needed to apply these Coordination of Benefits rules. The Plan has the right to decide which facts are needed. The Plan may get needed facts from, or give them to, any other organization or person. The Claims Administrator does not need to tell, or get the consent of, any person

to do this unless applicable federal or state law prevents disclosures of information without the consent of the patient or patient's representative. Each person claiming benefits under this plan must provide any facts needed to pay the claim.

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If this happens, the Claims Administrator may pay that amount to the organization that made that payment. That amount will then be considered a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the Plan pays more than it should have paid under these Coordination of Benefits rules, it may recover the excess from any of the following:

a) The persons it paid or for whom it has paid, or such person's legal representative
b) Any Insurance companies; and
c) Other organizations the amount paid includes the reasonable cash value of any benefits provided in the form of services.

11. COBRA

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses and dependent children may be qualified beneficiaries. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage.

Who is Entitled to Elect COBRA? If you are an employee, you will become a qualified beneficiary if you will lose coverage under the Plan due to one of the following qualifying events:

- your hours of employment are reduced; or
- your employment is terminated for any reason other than gross misconduct.

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

- employee dies;
- employee's hours of employment are reduced;
- employee's employment ends for any reason other than his or her gross misconduct;
- employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
- divorce or legal separation from Employee. Also, if your Spouse reduces or eliminates Your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for You even though Your coverage was reduced or eliminated before the divorce or separation.

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

- employee dies;
- employee's hours of employment are reduced;
- employee's employment ends for any reason other than his or her gross misconduct;
- employee retires at age 65 or over and enrolls in Medicare (Part A, Part B); or
- dependent child is no longer eligible for coverage because he or she no longer a "dependent child" under the Plan; or
- employee is divorced or legally separated, or same-sex domestic partnership is terminated.

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost). If you are an employee or former employee and you qualify for TAA or ATAA, **CONTACT THE PLAN SPONSOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.** Contact the Plan Sponsor for more information about the special second election period.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after Employee Benefits has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, or reduction of hours of employment Your coverage will terminate at the end of the month in which a qualifying event has occurred unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage.

Note: For other qualifying events – divorce or legal separation, or a dependent child losing eligibility for coverage – you must notify the Plan Administrator within 60 days after the qualifying event occurs or a COBRA election will not be available to you. You must either send a letter of notification to: Family & Child Learning Centers or call 715-369-5688. The Plan Administrator will send you the appropriate form to complete. This form must then be completed and sent to The Plan Administrator at the address above, and postmarked within the 60-day time limitation. Your coverage will terminate at the end of the month in which the qualifying event occurs unless you elect COBRA continuation coverage. You have 60 days from the date of loss of coverage to elect COBRA continuation coverage. If You do not follow these procedures or if notice is not provided to the Plan Administrator during the 60-day notice period **ALL QUALIFIED BENEFICIARIES WILL LOSE THEIR RIGHT TO ELECT COBRA.**

Once Employee Benefits notifies the Plan COBRA Administrator that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA, coverage will begin on the date the Plan coverage would otherwise have been lost.

Qualifying Events Determine Length of Coverage. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce or legal separation, or a dependent child losing eligibility, COBRA continuation coverage can be in effect for up to 36 months. When the qualifying event is the end of employment or a reduction in the employee's hours of employment, COBRA continuation coverage is available for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of the 18-month period of continuation coverage. If You or anyone in Your family who is currently covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first **60 days** of COBRA continuation coverage, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's (SSA) determination within **60 days** of the latest of:

- the date of the SSA determination,
- the date of the qualifying event,
- the date of the loss of coverage, or
- the date you are informed of your obligation and the procedure to provide this information,

and before the end of the 18-month period of COBRA continuation coverage. You must send this notice to the Plan Administrator. If you fail to notify the Plan Administrator in writing and postmarked within the time limit, you will lose your right to extend coverage due to disability. Under this provision, you must also notify the Plan Administrator within 30 days if the SSA determination is revoked.

Second qualifying event extension of the 18-month period of continuation coverage. If another qualifying event occurs during COBRA continuation coverage, Your spouse and dependent children in your family may be eligible for additional months of COBRA continuation coverage, up to a maximum of 36 months. The second qualifying event must be one that would have caused a loss of coverage if Your spouse and dependent children in Your family were not currently receiving COBRA continuation coverage. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), is divorced or legally separated, or has a termination of same-sex domestic partnership. The extension is also available to a dependent child who is no longer eligible under the Plan as a dependent child. In all of these cases, You must make sure that the Plan Administrator is notified in writing within **60 days** of the second qualifying event. You must send this notice to the Plan Administrator. If you fail to notify the Plan Administrator in writing and postmarked within the time limit, you will lose your right to extend coverage.

End of COBRA Continuation Coverage. Your COBRA continuation coverage may be terminated prior to the end of the continuation period for any of the following reasons:

- Employer no longer provides group insurance to any of its employees.
- The premium for your continuation coverage is not paid in a timely fashion.

Note: You will have 45 days from the date you elect COBRA continuation coverage in which to make your first premium payment to the Plan Administrator. After the first payment, there is a 30-day grace period for all future payments. For example: All regular COBRA continuation payments are due on the first day of the month. If your payment is due on January 1, your payment must be postmarked within 30 days or January 30. Payments made after the 30-day grace period will be returned to you and all coverage will be cancelled as of the end of the month in which the last regular payment was made.

- After making your COBRA election, you become covered under another group plan that does not include a pre-existing condition clause that applies to you or eligible dependent(s).
- After making your COBRA election, you or your dependents become covered under Medicare (Part A, Part B, or both). A final determination has been made by

the Social Security Administration that you are no longer disabled. Termination of coverage is effective in the month that begins more than 30 days after the final determination.

Keep Your Plan Informed of Address Changes. In order to protect the rights of you and your family, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices sent by you to the Plan Administrator. You can contact the Plan Administrator as indicated below.

Questions About Billing. The Plan Administrator is responsible for administering COBRA continuation coverage. If you have any questions about your billing, you should contact the Plan Administrator directly.

Questions About Coverage. If you have questions about your COBRA coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of the Regional and District EBSA Offices are available through the EBSA Web site at www.dol.gov/ebsa.

12. ERISA

As a Covered Person in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), 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 Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), 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 Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage. Continue health care coverage for Yourself if there is a loss of coverage under the Plan as a result of a Qualifying Event. You 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.

A reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under Your group health plan, if You have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from Your group health plan or health insurance issuer when You lose coverage under the plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after Your Enrollment Date in Your coverage.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan Covered Persons, 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 Covered Persons and beneficiaries. No one, including the Plan Administrator, 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 would 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 Administration, You should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (EBSA).

13. GENERAL PLAN INFORMATION

Type of Administration. The Plan is a self-funded Plan with administration provided by a third party administrator. Funding for payable benefits comes from the funds of the Employer and any contributions made by covered Employees.

Plan Name
Industrial Heat Transfer.
Employee Dental Welfare Benefit Plan

Plan Effective Date
June 1, 2014

Plan Administrator
Industrial Heat Transfer
300 Old Mill Road
Coon Valley, WI 54623
Phone: 608-452-3103

Tax ID Number
39-1530343

Named Fiduciary
Industrial Heat Transfer
300 Old Mill Road
Coon Valley, WI 54623
Phone: 608-452-3103

Agent for Service Of Legal Process
Jason Thomas
Industrial Heat Transfer

Administrative Services Manager
3PAdministrators
P.O. Box 247 or 1113 Riders Club Road
Onalaska, WI 54650
Phone: 608-779-3000 or 888-540-0094

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