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Summary Plan Description

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Introduction

This Summary Plan Description (SPD) is a guide to your dental plan. It is not the contract between Delta Dental Plan of Tennessee (DDPT) and your group nor any member of the plan. Should there be any conflict between the SPD and the contract, the contract will prevail.

I. Eligibility and Enrollment of Subscribers and Dependents

Subscribers who have enrolled in this dental plan through their employer or other group sponsoring this plan may also enroll their dependents.

Dependents are defined as a lawful husband or wife or child(ren) from birth to the Dependent Age Limit listed on the Benefit Summary Page. "Child" includes a natural child, step-child, adopted child, foster child or child in the subscriber's legal custody. A child over the Dependent Age Limit may continue to be eligible provided they continue to meet the support, maintenance and marriage requirements. In addition, the child must not be able to support themselves because of mental incapacity or physical handicap. Such disabling condition must have begun before reaching the Dependent Age Limit. Proof of these facts must be given to DDTN or group within 31 days if requested. Proof will not be required more than once a year.

Dependents in military service are not eligible.

An Eligible Employee or Dependent may enroll in this Plan within thirty-one (31) days from the Employee's Date of Hire and coverage shall become effective on the first day of the month following thirty (30) days from the Employee's Date of Hire, provided the Employee has commenced work and pays any required contributions.

Employees and/or Dependents who are not enrolled during the Initial Eligibility Period or a Special Enrollment Period must wait until the next Annual Enrollment Period to enroll for coverage. The Annual Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all eligible Employees and Dependents can enroll for coverage.

Special Enrollment Period - Loss of Coverage

This Plan shall permit Eligible Employees or Dependents who lose other coverage to enroll in this Plan, and shall not impose a pre-existing condition exclusion period longer than twelve (12) months with respect to such individuals, if all of the following conditions are met:

The Eligible Employee or Dependent was already covered by a group health plan or other health insurance when he declined coverage during the Standard Enrollment Period.

The Employee stated in writing at the time of the Standard Enrollment Period that another source of coverage was the reason for declining enrollment.

The Eligible Employee or Dependent was covered under COBRA continuation coverage which has been exhausted, or coverage was not under a

COBRA continuation provision and has been terminated as a result of a loss of eligibility for the coverage or termination of employer contributions towards such coverage. Loss of eligibility for coverage shall not include a loss coverage because of failure to pay premiums or contributions on a timely basis or any other termination of coverage for cause, including but not limited to, making a fraudulent claim or an intentional misrepresentation of fact in connection with a plan or policy.

The Eligible Employee or Dependent must request the right to enroll for coverage pursuant to Special Enrollment provisions of this Plan by enrolling in writing within thirty-one (31) days after the loss of other coverage.

Enrollment under this Special Enrollment Period section is effective on the first day following loss of coverage beginning after the date the valid request for enrollment is received.

Special Enrollment Period - New Dependents

This Plan shall permit Eligible Employees the opportunity to enroll in this Plan, and shall not impose a pre-existing condition exclusion period longer than twelve (12) months with respect to such individuals, if all of the following conditions are met:

The Employee is eligible for coverage but is not currently enrolled,

The Employee declined enrollment when offered coverage during the Standard Enrollment Period, and

An individual became a Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

This Plan shall permit Eligible Dependents the opportunity to enroll in this Plan if one of the following conditions is met:

The individual is a Spouse of the Employee and the individual's Child becomes a Dependent of the Employee through birth, adoption, or placement for adoption.

The individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

The Special Enrollment Period is thirty-one (31) days from the date of the marriage, birth, adoption, or placement for adoption. Failure to request enrollment during the Special Enrollment Period shall result in the waiver of the opportunity to enroll in this Plan until another enrollment period, if any, becomes available.

Enrollment under this Special Enrollment Period section is effective:

- In the case of marriage, the date of marriage.
- In the case of a Dependent's birth, the date of the birth.
- In the case of adoption or placement for adoption, the date of the adoption or the placement for adoption.

LEAVE OF ABSENCE

A leave of absence (LOA) is a period of time that an employee is away from work without pay and with the Company's approval. During LOA, the Group will maintain continuity of group insurance coverage during the leave on the condition that the employee pays the full premium (employer and employee portions) by the first of the month in which the premium is due. It is the employee's responsibility to make these arrangements with Human Resources.

TERMINATION OF COVERAGE

<u>For an Employee</u>

An Employee's coverage under this Plan will terminate at the earliest of the following times:

(a) For any Employee who fails to remit required contributions for his coverage when due, at the end of the period for which the last contribution was made.
(b) For an Employee, the last day of the month in which employment in an eligible class ceases; employment is considered to cease on the last day worked.
(c) For any Employee whose coverage has been extended under COBRA, at 12:00 midnight on the last day that the Employee is eligible for coverage through such an extension of coverage.
(d) For any Employee whose coverage has been continued under COBRA, at 12:00 midnight on the last day that the Employee is eligible for such coverage.
(e) At 12:00 midnight on the day that an

Employee becomes an active member of the armed forces of any country.
(f) At 12:00 midnight on the date that this Plan is terminated.
(g) At the time of the Employee's death.

For a Dependent

A Dependent's coverage under this Plan will terminate at the earliest of the following times:

(a) At the earliest of any time listed above when coverage ceases for the covered Employee.
(b) For any Dependent whose coverage has been continued under COBRA, at 12:00 midnight on the last day that the Dependent is eligible for such coverage.
(c) At 12:00 midnight on the day before a Dependent Child reaches the limiting age for non-student Dependents.
(d) At 12:00 midnight on the last day of the month in which a Dependent Child, who has already reached the limiting age for non-student Dependents, ceases to be a Full-Time Student.
(e) At 12:00 midnight on the day before a Dependent Child, who is a Full-Time Student, reaches the limiting age for Student Dependents.
(f) At 12:00 midnight on the date when a Dependent Child is legally married.
(g) At 12:00 midnight on the day that a Dependent becomes an active member of the armed forces of any country.
(h) At 12:00 midnight on the date when the Employee is relieved of a court-ordered obligation to furnish health care coverage for a Child.
(i) At 12:00 midnight on the date when a covered Dependent Spouse is legally separated or divorced from the covered Employee, or their marriage is legally annulled or dissolved.
(j) At the time of the Dependent's death.

DDPT will not pay for any services received by a patient who is not eligible at the time of treatment.

II. Choosing a Dentist

DDPT does not directly provide dental services and therefore is not liable for a dentist's refusal to provide services. It has contracted with "Participating Dentists". These dentists are independent contractors who have agreed to accept certain fees for the service they provide to you. Dentists that have not contracted with Delta Dental are referred to as "Non-Participating Dentists". The fact that a dentist has or has not chosen to participate with DDPT should not be viewed as a statement about their qualifications.

Although you are free to choose any dentist, your out of pocket expenses may be less if you choose a participating dentist. Therefore, you should always ask your dentist if he is a participating dentist or verify with DDPT that your dentist is a participating dentist before receiving any dental services.

DDPT is not responsible for any injuries or damages suffered due to the actions of any dentist. DDPT shares in the public concern over the spread of infectious disease, but it cannot require a dentist to be tested for them. Information about the need for clinical precautions as recommended by recognized health authorities is provided to dentists. If you have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

III. General Provisions

A. Participating dentists will file your claim with DDPT. If you need a claim form for services provided by a non-participating dentist you may contact DDPT which will provide you with a claim form. To be considered for benefits, a claim must be filed within 15 months of the date of service.

B. If you require emergency dental care, you may seek services from any dentist. Your out of pocket expenses may be less if you choose a participating dentist.

C. You may get an estimate of the cost of certain dental procedures before they are done. This estimate is referred to as a predetermination. You may have your dentist send DDPT a claim form detailing the projected treatment and DDPT will give an estimate of the benefits to be paid. A predetermination is not a guarantee of payment. Actual benefit payments will be based upon procedures completed and will be subject to continued eligibility along with plan limitations and maximums.

D. If you or your covered dependent receive an injury requiring dental treatment because of the action or fault of another person, and if DDPT is unaware of other coverage, DDPT

may pay benefits but would assume the subscriber's or covered dependent's rights to recover from the other person. The subscriber and covered dependent would be required to help DDPT in making such a recovery. This dental plan does not replace any workers' compensation coverage.

E. If a subscriber or covered dependent has two dental coverages, DDPT will coordinate benefits with the other coverage. The following rules will be used to determine which coverage should be primary.
   1. The program covering the patient as an employee is primary over a program covering the patient as a dependent.
   2. Where the patient is a dependent child, primary dental coverage will be determined by the date of birth of the parents. The coverage of the parent whose date of birth occurs earlier in the calendar year will be primary. For a dependent child of legally separated or divorced parents, the coverage of the parent with legal custody, or the coverage of the custodial parent's spouse (i.e. stepparent) will be primary.
   3. If there is a court decree stating that one parent has financial responsibility for a child's dental care expenses, any dependent coverage of that parent will be primary to any other dependent coverage.

When this plan is secondary, the Plan will use a Maintenance of Benefits method to determine how benefits will be coordinated. Under this method, the Plan's benefit is reduced so its benefit, combined with the primary plan's benefit does not exceed the benefit the Plan would normally pay for a service.

IV. Benefits

Not every dental procedure is a benefit of your dental plan nor are they paid at the same level of co-payment. The Schedule of Benefits in this SPD reflects the procedures that DDPT will cover as well as certain limitations and exclusions for these covered benefits. These services will be covered when a dentist or an employee of a dentist who is licensed to perform the service provides them. These services must be necessary and must be provided in accordance with generally accepted dental practice standards. Some allowable procedures are subject to deductibles, maximums, and copayments as described on the Group Variables Page.

In addition to the limitations and exclusions shown in the Schedule of Benefits section, DDPT does not pay for the following:

General Limitations and Exclusions

A. Treatment of injury or illness covered by Workers' Compensation or Employer's Liability Laws.
B. Services received without cost from any federal, state or local agency. This exclusion will not apply if prohibited by law.
C. Cosmetic surgery or procedures for purely cosmetic reasons.
D. Services for congenital (hereditary) or developmental malformations. Such malformations include, but are not limited to, cleft palate, or upper and lower jaw malformations. This does not exclude those services provided under Orthodontic benefits, if covered.
E. Treatment to restore tooth structure lost from wear.
F. Treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion or treatment to stabilize the teeth. For example: equilibration, periodontal splinting and double abutments on bridges.
G. Oral hygiene and dietary instructions, treatment for desensitizing teeth, prescribed drugs or other medication, experimental procedures, conscious sedation and extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
H. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.
I. Diagnosis or treatment for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.
J. Services by a dentist beyond the scope of his or her license.
K. Dental services for which the patient incurs no charge.
L. Dental services where charges for such services exceed the charge that would have been made and actually collected if no coverage existed.
M. Harmful habit appliances.
N. DDPT will apply the limitations and

exclusions of this benefit plan base upon the member's complete and prior history as reflected in DDPT's records.

In the event a member transfers from one dentist to another during the course of treatment, payment by DDPT will be limited to the amount that would have been paid had only one dentist rendered the service.

V. Optional Services

In cases where alternate or optional methods of treatment exist, DDPT will pay for the least costly professionally accepted treatment. This determination is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the subscriber's coverage. The dentist and subscriber or dependent should decide the course of treatment. If the treatment rendered is other than the covered benefit, the difference between DDPT's allowance and the dentist's fee, up to the approved amount, for the actual treatment rendered is due from the subscriber. For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, DDPT will pay for only the cost of the amalgam.

VI. Schedule of Benefits

In addition to the limitations and exclusions listed in the Schedule of Benefits, the **General Limitations and Exclusions** found in Section IV of this Summary Plan Description also apply.

A. Diagnostic and Preventive Benefits

a) Diagnostic -- oral examination and x-rays to aid the dentist in planning required dental treatment.
b) Preventive -- prophylaxis (cleaning), topical application of fluoride, and sealants.
c) Emergency palliative treatment

Limitations and Exclusions On Diagnostic And Preventive Benefits

a) Two oral exams and cleanings, to include periodontal maintenance procedures, in any calendar year.
b) Members with high risk health conditions may receive a total of four cleanings to include periodontal maintenance procedures in any 12 month period. Eligible members include diabetics and pregnant women with periodontal disease, those with renal failure, those with suppressed immune systems such as those undergoing chemotherapy/radiation treatment, HIV positive or organ or stem cell transplant patients or those at high risk for infective endocarditis.
c) Full mouth x-rays are covered once within 3 years, unless special need is shown.
d) Two sets of bite-wing x-rays in a calendar year.
e) Topical application of fluoride for members up to 14 years of age are allowed twice in a calendar year.
f) Adult prophylaxis for members under 14 years of age are not allowed.
g) Sealants are limited to children to age 16 and allowed once in a 5 year period to the permanent first and second molars only.
h) Consultations are not a benefit.

B. Basic Benefits

a) General Anesthesia & I.V. Sedation -- only when administered by a properly licensed dentist in a dental office in conjunction with covered surgery procedures covered under this plan.
b) Denture Repairs -- services to repair complete or partial dentures.
c) Basic Restorations -- amalgams (silver fillings) composites (white fillings), and prefabricated stainless steel crown restorations for the treatment of decay.
d) Simple extractions and complex oral surgery.
e) Space Maintainers.
f) Antibiotic injections.
g) Complete or Partial Denture Reline -- Chair side or laboratory procedure to improve the fit of the appliance to the tissue (gums).
h) Complete or Partial Denture Rebase -- Laboratory replacement of the acrylic base of the appliance.

Limitations and Exclusions On Basic Benefits

a) Restorative benefits are allowed once per surface in a 24 month period, regardless of the number or combinations of procedures requested or performed.
b) The replacement of a stainless steel crown on a primary tooth by the same dentist or dental office within a 24 month period of the initial placement is not a benefit.

c) The replacement of a stainless steel crown on a permanent tooth by the same dentist or dental office within a 60 month period of the initial placement is not a benefit.
d) Gold foil restorations are an Optional Service.
e) Space maintainers are covered to age 16 per space once in a lifetime.

C. Major Benefits

a) Endodontia -- treatment of the dental pulp (root canal procedures).
b) Periodontia -- treatment of the gums and bones that surround the tooth.
c) Cast Restorations **–** Crowns, inlays and onlays are benefits for the treatment of visible decay and fractures of hard tooth structure when teeth are so badly damaged that they cannot be restored with amalgam or composite restorations.
d) Prosthodonics **--** Procedures for construction of fixed bridges, partial or complete dentures and repair of fixed bridges.

Limitations and Exclusions On Major Benefits

a) Payment for root canal treatment includes charges for x-rays and temporary restorations. Root canal treatment is limited to once in a 24 month period by the same dentist or dental office.
b) Payment for periodontal surgery shall include charges for three months post operative care and any surgical re-entry for a three year period. Root planing, curettage and osseous surgery are not a benefit for members under 14 years of age.
c) Replacement of crowns or cast restorations received in the previous five years is not a benefit. Payment for cast restorations shall include charges for preparations of tooth and gingiva, crown build-up, impression, temporary restoration and any re-cementation by the same dentist within a 12 month period.
d) A cast restoration on a tooth that can be restored with an amalgam or composite restoration is not a benefit.
e) Procedures for purely cosmetic reasons are not benefits.
f) Porcelain, gold or veneer crowns for children under 12 years of age are not a benefit.
g) Replacement of any fixed bridges or partial or complete dentures that the member received in the previous five years is not a benefit.
h) Payment for a complete or partial denture shall include charges for any necessary adjustment within a six month period. Payment for a reline or rebase of a partial or complete denture is limited to once in a three year period and includes all adjustments required for six months after delivery.
i) Payment for standard dentures is limited to the maximum allowable fee for a standard partial or complete denture. A standard denture means a removable appliance to replace missing natural, permanent teeth. A standard denture is made by conventional means from acceptable materials. If a denture is constructed by specialized techniques and the fee is higher than the fee allowable for a standard denture, the patient is responsible for the difference.
j) Payment for fixed bridges or cast partials for children under 16 years of age is not a benefit.
k) A posterior bridge where a partial denture is constructed in the same arch is not a covered benefit.
l) Temporary partial dentures are a benefit only when upper anterior teeth are missing.

D. Implants Benefits, Limitations & Exclusions Implants. The surgical placement of an endosteal (in the bone) implant and the connecting abutment are covered benefits.

a. Replacement of implants or abutments received in the previous five years is not a benefit.
b. The removal of an implant is allowed once per lifetime.
c. Specialized techniques are not benefits (ie. bone grafts, guided tissue regeneration, precision attachments, etc.)

Implant maintenance procedures are allowed once in a 12 month period.

E. Orthodontic Benefits

As shown on the Group Variables page, DDPT will pay benefits for procedures using appliances to treat poor alignment of teeth and/or jaws. Such poor alignment must significantly interfere with function to be a

benefit.

Limitations and Exclusions On Orthodontic Benefits

a) Orthodontic benefits are limited to members shown on the Group Variables Page.
b) DDPT shall make regular payments for orthodontic benefits.
c) If orthodontic treatment began prior to enrolling in this plan, DDPT will begin benefits with the first payment due the dentist after the subscriber or covered dependent becomes eligible.
d) Benefits end with the next payment due the dentist after loss of eligibility or immediately if treatment stops.
e) Benefits are not paid to repair or replace any orthodontic appliance received.
f) Orthodontic benefits are not paid for extractions or other surgical procedures. However, these additional services may be covered under Diagnostic and Preventive or Basic Benefits.

Orthodontic Payment Method

a) The initial payment (initial banding fee) made by DDPT for comprehensive treatment will be 33% of the total fee for treatment subject to your copayment percentage and lifetime maximum.
b) Subsequent payments will be issued on a regular basis for continuing active orthodontic treatment. Payments will begin in the month following the appliance placement date and are subject to your copayment percentage and lifetime maximum.

VII. CONTINUATION OF COVERAGE UNDER COBRA

A Eligibility for Coverage under COBRA

If a Participant's coverage under this Plan terminates because of a "Qualifying Event", and the Participant was covered under this Plan on the day before the Qualifying Event, this Plan will offer the Participant the opportunity to continue coverage as a "Qualified Beneficiary" in compliance with the Consolidated Omnibus Budget Reconciliation Act of 1986, as amended (COBRA).

A "Qualified Beneficiary" is an Employee, Spouse and/or Dependent Child who was covered under this Plan on the day before a Qualifying Event, and who loses coverage as a result of the Qualifying Event. A Child who is born to the covered Employee, or who is placed for adoption with the covered Employee, during a period of COBRA continuation coverage is also a Qualified Beneficiary.

A "Qualifying Event" for a Participant is any of the following which results in a loss of coverage for that Participant:

(1) Termination of the Employee's employment for reasons other than gross misconduct.
(2) Reduction in the Employee's working hours to the extent that the Employee is no longer eligible to participate in this Plan.
(3) The Employee's death.
(4) Divorce or legal separation of the Employee from the Employee's Spouse.
(5) The Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act
(6) A Dependent Child no longer satisfies this Plan's definition of "Dependent Child".

If any of the events listed in (1) through (6) immediately above results in an increase in contribution which a Participant must pay to remain covered under this Plan, that increase in contribution will also be considered a Qualifying Event and a loss of coverage.

Coverage under COBRA will be identical to coverage offered under this Plan to similarly-situated Employees, as such coverage under this Plan may change from time to time. Each Qualified Beneficiary under COBRA shall have all the rights of an Employee under this Plan, including the right to enroll dependents, if such right is given to Employees; however, other than a child born to the Employee or placed for adoption with the Employee during a period of COBRA continuation coverage, any such dependent so enrolled, who was not covered under this Plan on the day prior to the initial Qualifying Event, although eligible for coverage under COBRA, shall not have the status of Qualified Beneficiary.

B Initial Notification of a Qualifying Event

If the Qualifying Event is a divorce or legal

separation, or a Dependent Child no longer satisfying this Plan's definition of "Dependent Child", the Qualified Beneficiary eligible for COBRA as a result of such Qualifying Event must notify the Plan Administrator of the Qualifying Event, in writing, within sixty (60) days of (a) the Qualifying Event, or (b) the date on which coverage is lost as a result of the Qualifying Event, whichever is later. If the Plan Administrator is not so notified, the Qualified Beneficiary may not enroll in COBRA. In the event of a divorce or legal separation, notice sent to the Plan Administrator by any one of the Participants for whom the divorce or legal separation constitutes a Qualifying Event will be considered notice sent on behalf of all such Participants.

For all other Qualifying Events, the Employer will notify the Plan Administrator of a Qualified Beneficiary's Qualifying Event within thirty (30) days of such event. The Plan Administrator will then notify all Qualified Beneficiaries, in writing, of their rights to continue coverage under COBRA, within fourteen (14) days following the thirty-day period specified above in this paragraph.

C Electing COBRA

If a Qualified Beneficiary wishes to enroll in COBRA, he must so notify the Plan Administrator, in writing, within sixty (60) days of the date the Plan Administrator mails written notification of the right to continue coverage, except that if loss of coverage occurs after the date of the Qualifying Event, the sixty (60) days shall be counted from the date coverage is lost. An election is considered to be made on the date it is mailed to the Plan Administrator.

Each Qualified Beneficiary may make his own independent election to receive or not receive COBRA coverage. If an Employee or a Spouse of an Employee, which such person is a Qualified Beneficiary, elects COBRA and does not specify his election is self-only, the election will be deemed to include election of COBRA for all Qualified Beneficiaries with respect to that Qualifying Event. An election on behalf of a minor child may be made by the child's parent or legal guardian.

If notice of election is not sent to the Plan Administrator within the period specified in the paragraph immediately above, the Qualified Beneficiary may not enroll in COBRA.

A Participant who waives his right to COBRA during the initial 60-day period discussed in the first paragraph of this Section C may, at any time during such 60-day period, revoke his waiver and enroll in COBRA; however, coverage under COBRA will be effective as of the date the revocation of the waiver is sent to the Plan Administrator, and will not be made retroactive to the date coverage would have been in effect had the waiver not been made.

The right to revoke a waiver expires at the end of the initial 60-day period discussed above in this Section C.

D Payment for COBRA

The cost to a Qualified Beneficiary for COBRA coverage shall be 102% of the Employer's cost, or 150% of the Employer's cost during an 11-month extension for disability (as explained below), for such coverage.

A Qualified Beneficiary's first payment for COBRA is due forty-five (45) days after the date of his election. All subsequent payments are due within thirty (30) days of the first day of coverage such payment represents, or within the period of time allowed under this Plan for covered Employees, whichever is later. Payment is considered to be made on the date on which it is sent to this Plan.

Failure to pay any contributions due within the timeframes specified in this Section D will result in cancellation of COBRA coverage, such cancellation to be effective as of the end of the last day for which coverage has been paid. COBRA does not require that the Qualified Beneficiary be notified in the event cancellation of COBRA coverage has occurred.

E Length of COBRA Coverage

(1) For Covered Employees, Spouses and Dependent Children

If the Qualifying Event is an Employee's termination of employment for reasons other than gross misconduct, or reduction in hours worked to the extent that the

Employee is no longer eligible for coverage under this Plan, COBRA may be continued for up to eighteen (18) months for all Participants who become Qualified Beneficiaries as a result of such event.

If a Qualified Beneficiary is disabled on the day of either Qualifying Event discussed in the paragraph immediately above, or becomes disabled during the first sixty (60) days of COBRA coverage, COBRA coverage for all Qualified Beneficiaries in the disabled Qualified Beneficiary's family may be continued for an additional eleven (11) months beyond the original eighteen (18) months, regardless of whether or not the disabled individual himself elects the 11-month extension. As used herein, "disabled" means the Qualified Beneficiary has been determined under Title 2 or Title 16 of the Social Security Act to be disabled. The "first sixty (60) days of COBRA coverage" is counted from the date of the Qualifying Event or the date coverage would actually be lost, whichever is later.

For the 11-month extension to apply, the Qualified Beneficiary must notify the Plan Administrator, in writing, of the determination of disability, such notification to be within the initial 18-month period of COBRA, and not more than sixty (60) days after the date on which the determination was made by the Social Security Administration. If the disabled Qualified Beneficiary is later determined by the Social Security Administration to no longer be disabled, he must so notify the Plan Administrator, in writing, within thirty (30) days of such redetermination. If the redetermination occurs during the initial eighteen (18) months of COBRA, coverage may continue until the end of the eighteen (18) months. If the redetermination occurs during the 11-month extension, coverage will cease for all Qualified Beneficiaries as of the month that begins more than thirty (30) days after the date of the redetermination.

If a Qualified Beneficiary first becomes disabled more than sixty (60) days after COBRA has begun, or fails to notify the Plan Administrator as explained above within the 18-month period, the 11-month extension does not apply.

(2) For Spouses and Dependent Children

If the Qualifying Event is other than the two specified in (1) directly above, COBRA coverage may be continued for up to thirty-six (36) months for any Spouse or Dependent Child(ren) who become Qualified Beneficiaries as a result of such Qualifying Event.

(3) Multiple Qualifying Events

If a second Qualifying Event occurs during COBRA coverage, in no event will coverage under COBRA be extended beyond a maximum of thirty-six (36) months from the date of the initial Qualifying Event. Termination of employment following the Qualifying Event of reduction in hours is not a second Qualifying Event.

F <u>Early Termination of COBRA Coverage</u>

COBRA coverage shall terminate earlier than the 18-, 29- and 36-month time periods given in this Section 3.5 if any of the following occur:

(1) The Employer ceases to offer any group health plan (including successor plans) to any employee (COBRA will terminate on the day such coverage ceases); or
(2) The Qualified Beneficiary does not pay his contributions for COBRA within the time frames specified herein (COBRA will terminate on the last day of the period for which contributions have been made); or
(3) The Qualified Beneficiary becomes entitled to Medicare, provided such entitlement first occurs after the date of the Qualifying Event (COBRA will terminate on the date of entitlement); or
(4) The Qualified Beneficiary becomes covered under another group health plan, in any capacity, even if that other coverage is of lesser value, provided such coverage first becomes effective after the date of the Qualifying Event, and provided the plan does not limit coverage for Pre-Existing Conditions which apply to the Qualified Beneficiary, or has such limits but such limits do not apply to the Qualified Beneficiary because of

Creditable Coverage (COBRA will terminate on the date coverage under the other plan becomes effective).

In addition, COBRA coverage for a Qualified Beneficiary may be terminated at any time for cause, to the degree coverage for a similarly-situated Employee's coverage under this Plan may be terminated for cause.

If an individual who is not a Qualified Beneficiary is receiving COBRA coverage solely because of his relationship to a Qualified Beneficiary, that individual's coverage under COBRA will cease at the same time as the Qualified Beneficiary's coverage ceases. Such loss of COBRA coverage shall not constitute a Qualifying Event.

REINSTATEMENT OF COVERAGE

A COBRA Participants

An Employee who has elected COBRA continuation of coverage will be considered to have had no lapse of coverage, provided that the coverage is in effect on the day before the Employee returns to eligible employment.

B Reinstatement of Coverage Following a Military Leave of Absence

Regardless of an Employer's established leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering military service. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

VIII.CLAIMS APPEAL PROCEDURES

APPEAL PROCESS

In cases where a claim for benefits payment is denied in whole or in part, the Participant or his or her representative may appeal the denial. This appeal provision will allow the Participant to:

(A) Request from the Plan a review of any claim for benefits. Such request must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim and must include:

(i) Employee name
(ii) Covered Employee's SSN
(iii) Name of the patient and,
(iv) Group Identification, if any

(B) Submit written comments, documents, records, and other information relating to the claim.

(C) Request, free of charge, reasonable access to documents, records, and other information relevant to the Participant's claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The request for review must be directed to the Claims Administrator within 180 days after the claim payment date or the date of the notification of denial of benefits.

The review of the denial will be made by the Plan Administrator, or by an appropriate named fiduciary who is neither the party who made the initial claim determination nor the subordinate of such party. The review will not defer to the initial claim determination and will take into account all comments, documents, records and other information submitted by the Participant without regard to whether such information was previously submitted or relied upon in the initial

determination. In deciding an appeal of any denied claim that is based in whole or in part on a dental judgment, the Plan must consult with an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied claim that is the subject of the appeal nor the subordinate of any such individual.

The Plan Administrator will provide the Participant with a written response: Within 60 calendar days after receipt of the Participant's request for review.

If a claim on review is wholly or partially denied, the written notice will contain the following information:

(A) The specific reason(s) for the denial and reference to the specific Plan provisions on which the denial is based. If a protocol was followed in making the determination, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to the Participant free of charge upon request. If the claim was denied because it does not meet the definition of a Dental Expense or is experimental in nature, or if denial is due to a similar exclusion or limit, then the notice will state that an explanation of the scientific or clinical judgment used in applying the terms of the Plan to the Participant's dental circumstances can be provided free of charge to the Participant upon request, including the names of any dental professionals consulted during the review process.

(B) A statement that the Participant is entitled to receive upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Participant's claim.

(C) A statement of the Participant's right to bring a civil action under section 502(a) of ERISA.

(D) A statement notifying the Participant about potential alternative dispute resolution methods, if any.

If the Participant feels the Plan has not complied with the established Plan Claim Procedures, there are steps the Participant can take to enforce their rights. For additional information, please refer to the ***EMPLOYEE RIGHTS UNDER ERISA*** section of this plan description

LIMITATION

No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.

No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Plan Administrator.

RIGHTS OF EMPLOYEES PARTICIPATING IN THIS PLAN

NON-DISCRIMINATION

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between individuals in comparison to similar situations at the time of such action.

CHOICE OF SERVICE

The persons covered under this Plan have the sole right to select their own providers of health care. This Plan will not choose a provider for any Participant, or have any liability for any acts, omissions, or conduct of any provider. This Plan's only obligation is to make payments according to the terms of this Master Plan Document and Plan Description. The payments which this Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

ASSIGNMENT OF BENEFITS

A Participant will have the right to assign the payment of any Benefits for which he is eligible under this Plan to any eligible Provider of services. If a Provider makes a representation to the Claims Administrator that a person covered under this Plan has made an assignment of Benefit payments to the Provider, the Claims Administrator will make payment to the Provider based on that

representation.

EMPLOYEE RIGHTS UNDER ERISA

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

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
(b) 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.
(c) Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you 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 preexisting 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 Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare Benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

In addition, if you disagree with the Plan's decision or lack thereof concerning the

qualified status of a 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 the 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Welfare Benefits Administration.