WAKE FOREST
UNIVERSITY

Dental Program

Summary Plan Description (SPD)

As Amended and Restated
Effective August 1, 2005

TO ALL FACULTY AND STAFF:

Visiting your dentist regularly is one of the best ways to prevent serious and costly dental problems. The Wake Forest University Dental Insurance Program (the Program) provides coverage designed to protect you and your family from high, and sometimes unexpected, dental care expenses.

Read this information carefully so you understand the program and can make the decisions that best fit your individual situation. If you have questions regarding the program or this summary plan description, contact the Benefits Office in Human Resources.

This Summary Plan Description has been developed to help you learn about and understand your benefits. After reading the summary plan description, you should understand how the program works and how you can use the program most effectively. Of course, the benefit plan outlined in the materials is based on the law, plan documents, and/or insurance contracts. The Plan administrator has the authority to interpret the program provisions, and to exercise discretion where necessary or appropriate in the interpretation and administration of the program.

This Summary Plan Description contains a summary in English of your Plan rights and benefits under your Group Health Plan. If you speak Spanish only and have difficulty understanding any part of this Summary Plan Description, contact Josie Longo at (336) 759-2013, ext. 1260. Office hours are from 8:00 a.m. to 5:00 p.m. (Eastern Time) Monday through Friday.

Este Sumario de Beneficios contiene un Sumario de Beneficios en ingles de derechos del paciente y cobertura. Si es dificil entender cualquier parte de este Sumario de Beneficios, por favor ponerse en contacto con Josie Longo (336) 759-2013 Ext. 1260, durante las horas 8:00 - 5:00 del dia, los lunes a viernes.

Although this program has been summarized, this summary plan description does not replace the legal documents governing the program. If there are any differences between this information or any statements made by plan representatives and the official Plan Document, the Plan Document governs.

In addition, please keep in mind that although Wake Forest University intends to continue the program in its present form, the program is subject to changes in legislation and/or business conditions that could affect how the program is administered or used. Therefore, Wake Forest University, of its sole discretion, reserves the right to amend, suspend, or terminate, in whole or in part, the program at any time.

These modifications or terminations may be made for any reasons Wake Forest University or its representatives consider appropriate. If that occurs, you will be notified.

Nothing in this summary plan description says or implies that participation in the benefit program is a guarantee of continued employment with Wake Forest University. Nor is anything in this summary plan description intended to guarantee that benefit levels will remain unchanged in future years.

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SCHEDULE OF BENEFITS

DENTAL BENEFITS

	High Option	Low Option
Benefit Year Deductible - Individual	$50	$50
Benefit Year Deductible - Family	$150	$150
Maximum Benefit Per Year		
High Option for Type A, B and C Services Only	$1,500	
Low Option for Type A and B Services Only		$500
Lifetime Maximum Benefit	Not Applicable	Not Applicable
Not Subject to Deductibles		
Type A (Preventative) - Plan Copayment Rate	100%	100%
Fluoride Treatment for Dependent Child to Age:	Nineteen (19)	Nineteen (19)
Subject to Deductibles		
Type B (Basic Service) - Plan Copayment Rate	80%	80%
Type C (Major Service) - Plan Copayment Rate	50%	No Coverage
Type D (Orthodontics) - Plan Copayment Rate	50%	No Coverage
Maximum Lifetime Benefits for Orthodontics Only	$1,500	No Coverage
Lifetime Deductible	None	No Coverage
Orthodontics For Dependent Child:	Yes	No Coverage
Orthodontics For Employee and Spouse:	Yes	No Coverage

Dental Benefits are Elective for the Participant/Dependent. Elective means the Participant/Dependent may choose dental coverage whether or not medical coverage is chosen.

Individual Lifetime Maximum For Orthodontics
The Individual Lifetime Maximum Benefits for orthodontics are measured from July 1, 2001.

Plan Selection
Once the High Option Plan has been selected, Participants and Covered Dependents must remain in the High Option Plan for at least two (2) years before electing the Low Option Plan or terminating High Option Coverage.

ELIGIBILITY FOR THIS PLAN

Eligibility
You are eligible for coverage under this Plan if you are in one of the following classes:

Class I	Full-time regular faculty (budgeted to work between 1,096 and 1,462 hours per year).
Class II	Full-time regular staff and administrators (budgeted to work between 1,400 and 2,080 hours per year).
Class III	Regular part-time faculty (budgeted to work at least 1,000 hours per year but less than 1,096 hours per year) and regular part-time staff and administrators (budgeted to work at least 1,000 hours per year but less than 1,400 hours per year).
Class IV	Retirees as defined in the policies of Wake Forest University.
Class V	Widows, widowers and/or dependents of deceased retirees or employees.
Class VI	Disabled employees.
Class VII	Phased Retirement Program Employees.

The following individuals are **not** eligible to participate:

- Temporary staff employees and adjunct faculty (budgeted to work less than 1,000 hours);
- Consultants;
- Exchange visitors;
- Independent contractors;
- Leased employees; and
- Students

Your Family's Eligibility

You may enroll your eligible dependents for coverage in the Plan. A dependent's coverage begins at the same time your coverage begins. Your eligible dependents include:

- Your lawful/legal spouse;
- Your unmarried child(ren), from birth up to the end of the month in which they turn 19;
- Your unmarried child(ren), age 19 up to the end of the month in which they turn 26, if they are full-time students in an accredited school and dependent on you for primary support and care;
- Your same sex domestic partner and their dependents, as defined by the policies of Wake Forest University;
- Your child(ren) with a physical disability or who is mentally retarded and who is over the age limit. The child(ren) is eligible if he/she becomes and remains disabled or mentally retarded while covered under this program, or was covered under the prior program that this program replaces and: has not been married; cannot hold a self-supporting job due to the disability; and depends on you for primary support and care.

Your "child(ren)" include:

- Your own natural or adopted children, or children placed for adoption with you;
- Stepchildren who are primarily dependent on you for support;
- A child of a domestic partner (as defined by the policies of Wake Forest University); and
- A child for whom you have been appointed legal guardian, or a foster child.

In all cases, the child must depend upon you for his/her primary support and care.

If you and your spouse/partner both work for Wake Forest University, you may each be covered as an employee or as a dependent, but not both. Your dependent children may be covered by either of you, but not both.

Dependents

The definition of dependent shall include same sex domestic partners and their dependent children as defined by the Plan Administrator.

Effective Date of Coverage

If you meet these eligibility requirements, your coverage effective date is the first day of the month following or coinciding with your date of employment or transfer to regular full-time or part-time status. Newborn or adopted children are covered from the date of birth or placement in the adoptive home, provided they are enrolled within thirty (30) days of birth or placement. Such thirty (30) day period is extended to ninety (90) days from the date of birth for a newborn or from the date of placement for adoption for an adopted child in cases in which the addition of such dependent does not affect the employee's contribution to the Plan. Dependents may also be added if enrolled within thirty (30) days of their second (2^{nd}) birthday.

Eligibility Waiting Period

Eligibility Waiting Period means that period from the date of hire to the first day of the month coinciding with or following the date of hire following continuous regular full-time or part-time service, actively-at-work. Dependents may be added within thirty (30) days of their second (2nd) birthday.

Actively-at-Work

The definition of actively-at-work in this Plan shall include employees who are receiving short term or long term disability benefits under the Wake Forest University sponsored short term disability and long term disability plans. Actively-at-work shall also include that period of time from the first day of the month in which a newly hired Faculty Member's appointment is scheduled to begin until the start of either the Fall or Spring semester, whichever comes first. An Employee shall be deemed actively-at-work on each day of a regular paid vacation, leave of absence or regular non-working day, provided the Employee was actively-at-work on the last preceding regular work day.

Unmarried Child's Eligibility Age

Unmarried Child's Eligibility Age means through age 18 (that is, to such child's 19th birthday); such eligibility is extended through age 25 (that is, to such child's 26th birthday) if such Dependent Child is a full-time student in high school or an accredited school, college or university as listed in the most recent edition of The Directory of Higher Education. "Full-time" is the period of attendance which the accredited school, college or university considers full-time, as determined by the rules of the educational institution. A child's dependent status terminates upon his or her being employed full-time for wages, profit or gain. The Participant must notify the Plan Administrator within thirty (30) days of the date when a dependent child loses eligibility under this paragraph.

Physically Handicapped and/or Mentally Retarded Dependent Children will be covered regardless of age if satisfactory proof of condition is provided and approved by the Plan Supervisor. To be eligible for coverage, a physically handicapped or mentally retarded child must be unmarried, incapable of self-support because of condition, and principally dependent upon the Participant for financial support. Proof of condition may be required once each year.

Annual Enrollment

This Dental Program allows enrollment annually from May 1 through June 30 of each calendar year. The effective date of coverage for employees or dependents who apply during this Annual Enrollment period will be July 1. Such Enrollment Period permits otherwise-eligible employees who have been in the Eligibility Class for longer than the Eligibility Waiting Period, or their dependents, to apply for coverage during this Enrollment Period without being considered a Late Enrollee. The Pre-Existing Condition Provisions are not waived for any employees or dependents enrolled during such Enrollment Period. Dental participants may change from High Option to Low Option or from Low Option to High Option during this Annual Enrollment period. Once the High Option Plan has been selected, Participants and dependents must remain in the High Option Plan for at least two (2) years before electing the Low Option Plan or terminating High Option coverage.

Late Enrollment

This Plan does not allow *Late Enrollment* unless the Plan requires or permits the employee/parent of a Qualified Medical Child Support Order (QMCSO) Alternate Recipient to enroll while the QMCSO is in effect. With the possible exception of QMCSO, this Plan does not allow *Late Enrollment* at a time other than the Annual Enrollment Period and any reference to *Late Enrollment* or *Late Enrollees* is not applicable. If required or permitted by the Plan Sponsor to enroll, the effective date of coverage for an employee/parent of a QMCSO Alternate Recipient is the effective date of the QMCSO Alternate Recipient.

Parent/Employee of a Qualified Medical Child Support Order Alternate Recipient

The Parent/Employee of a Qualified Medical Child Support Order Alternate Recipient is required to enroll in the Plan. The effective date of coverage for an employee/parent of a QMCSO Alternate Recipient is the effective date of the QMCSO Alternate Recipient. The Alternate Recipient will also be a *Late Enrollee*, subject to an eighteen (18) month pre-existing condition waiting period, unless *Special Enrollment* rules apply or the Alternate Recipient is being enrolled at the time the Parent/Employee is first eligible.

Late Enrollee

Late Enrollee means a person who fails for any reason to apply for coverage other than on the earliest date on which coverage can be effective, or other than under the *Special Enrollment* Rules. This provision does not apply if this Plan does not allow *Late Enrollment*. See *Late Enrollment.*

Coverage When Both Spouses are Employees

In those instances where both husband and wife are employees of the Plan Sponsor, dependent children of such employees may be covered under the Plan as dependents of either parent but not both. Employees who are spouses of employees may be covered either as dependents of their spouses or as individuals, but not both.

Exhaustion of COBRA Coverage

This Dental Program will not require a person who has elected COBRA coverage in lieu of coverage under this Plan when coverage under this Plan was first available to exhaust such coverage in order to be eligible to enter this Plan as a Special Enrollee.

Loss of Eligibility

This Dental Program will allow loss of eligibility to mean loss of coverage under another group health plan as a result of a significant decrease in other plan benefits or a significant increase in premiums, as determined by the Plan Administrator.

Leave of Absence Period

Leave of Absence Period means twenty-four (24) months, but in the case of qualifying Family and Medical Leave, in no event will the Leave of Absence Period be less than that period mandated by the Federal Family and Medical Leave Act of 1993 and clarifying regulations and other pertinent federal laws and regulations.

If an Employee takes FMLA leave, the Employer will continue to maintain the Employee's coverage under the Plan to the extent required by the FMLA (that is, the Employer will continue to pay its share of the premium to the extent that the Employee opts to continue coverage). If the Employee's coverage ceases during the FMLA leave (for example, because the Employee opted not to continue coverage or due to non-payment of the Employee's share of the premiums), the Employee may resume his or her coverage upon return from FMLA leave on the same terms as before the leave was taken, or as otherwise required by the FMLA. Under special rules that apply if an Employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during leave. Contact the Plan Administrator for additional information about these special rules.

Disability Extension Period

Please refer to the Wake Forest University disability policies.

Termination of Coverage Date

Termination of Coverage Date means the last day of the calendar month coinciding with or following the day eligibility is lost. This applies to covered employees and dependents (including dependent children who lose full-time student status).

Severance Agreements

If an employee accepts a severance package at the time of employment termination, the termination of coverage under this Plan will be determined by the terms of such severance agreement.

TERMS AND PHRASES

Employer (and Plan Sponsor)

Employer Name:	Wake Forest University		
Address:	1834 Wake Forest Road		P.O. Box 7424
City, State, Zip:	Winston-Salem, NC 27106		Winston-Salem, NC 27109
EIN: 56-0532138			
Tel: 336-758-5241	Fax:	336-758-6127	

Participating Employers

Wake Forest University and The Reynolda House Museum of American Art.

Plan Name
Wake Forest University Health and Welfare Benefit Plan.

Plan Numbers
Plan Numbers for Administration Purposes are SF 954 (active employees with High Option Dental), SF 955 (retirees with Prescription Drugs and High Option Dental), SF 001 (active employees with Low Option Dental), SF 002 (retirees with Prescription Drugs and Low Option Dental), SF 003 (High Option Dental only), SF 004 (Low Option Dental only) and SF 074 (out of state employees with Low Option Dental).

ERISA Plan Number
ERISA Plan Number is 501.

Effective Date of the Plan
The Effective Date of the Plan is July 1, 1991, restated August 1, 2005. Plan year is from July 1 to July 1.

Type of Plan
The type of Plan is welfare plan providing dental coverage.

Plan Trustees
None. The Plan is not administered under a trust.

Benefit Year
The Benefit Year is Calendar Year.

Plan Year
The Plan Year ins the twelve (12) month period from July 1 to July 1.

Plan Supervisor
Plan Supervisor means ACS Benefit Services, Inc., 8025 North Point Boulevard, Winston-Salem, NC 27106, tele. 336-759-2013, or its successor as may be appointed by the Employer. The Plan Supervisor receives and processes claims for benefits on behalf of the Plan Administrator.

Plan Administrator
Plan Administrator means the Employer, administering the Plan by contract through a third party administrator. Plan Administrator is also the Named Fiduciary and Agent of Legal Service of Process. The Plan Administrator has the final authority and responsibility to review and make final decisions on all Plan matters such as benefit adjudication and appeals, eligibility for coverage determinations and construing terms.

Plan Coordinator
The Plan Coordinator is Benefits Manager or a successor as shall be named by the Employer.

Claim Filing Period
The Claim Filing Period is one hundred eighty (180) days. Claims must be submitted within one hundred eighty (180) days of the incurred date or your claims will not be paid.

Coordination of Benefits

Coordination of Benefits (COB) Percent means 100%. Under 100% Coordination of Benefits, the Plan will pay the entire balance of an allowable charge as long as that amount does not exceed the allowable charge. Sometimes this calculation will result in no additional amount paid. For coordination of benefits for dependent children, the method of determining which plan is primary is the Birthday Rule. This means that the primary plan will be the plan of the parent whose birthday is the earliest in the calendar year.

Plan Funding

Are Participant Contributions Required?

Benefit	Funding	WFU Participant Coverage	Reynolda House Participant Coverage	WFU and Reynolda House Dependent Coverage
Dental	Self-Funded	Yes	No	Yes

Contributions for Plan expenses are obtained from the employer and from covered employees. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees. The employer reserves the right to change the required contribution amount. Contributions by the covered employees are deducted from their pay on a pre-tax basis as authorized by the employee on the enrollment form or other applicable forms.

The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

Full-time employees pay a portion of the total cost of the coverage to the employer. Part-time employees and retirees pay the full cost of their coverage. No health insurance issuer is responsible for the financing or administration of this Plan.

Benefits Not Covered By This Plan

Major Medical, Immunization Benefits, Hearing Care Benefits, Vision Care Benefits and Routine Physical Benefits are not provided under this Plan.

Benefits Processing Guides

This plan uses *Trilogy Claims Administration Handbook* as a benefit administration manual. As a source for reasonable and customary charges, this Plan uses *Ingenix*. As guides for procedural coding, this Plan uses the American Medical Association's Current Procedural Terminology (CPT) Manual, The Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual and National Correct Coding Initiative Tables and other nationally recognized coding guidelines.

EXPLANATION OF DENTAL BENEFITS

Benefits in General

If you or your Covered Dependents incur covered dental expenses, you will be paid benefits subject to the following provisions. These benefits will be equal to the applicable percentage of the amount by which covered dental expenses in any Benefit Year exceed the Dental Deductible Amount. The applicable percentage and applicable Dental Deductible Amount are specified in the Schedule of Benefits. Benefits will be determined separately for each Covered Person.

Maximum Dental Benefits

The maximum dental benefits, if any, for each Covered Person are shown in the Schedule of Benefits. Not more than the applicable maximum Benefit Year dental benefit will be paid for expenses incurred for any Covered Person in a calendar year. Not more than the applicable Lifetime Maximum Benefit will be paid for expenses incurred for any Covered Person in all Benefit Years.

When a Dental Expense is Incurred

A dental Expense is deemed incurred as follows:

1. for an appliance or change to an appliance, when the impression is made;
2. for a crown, bridge or gold restoration, when the tooth or teeth are prepared for the procedure;
3. for root canal therapy, when the pulp chamber is opened;
4. for other dental services, when the service is rendered or the supply is received.

Covered Dental Expenses

The following types of dental procedures are covered dental expenses, provided the procedures are necessary and are performed or prescribed by a licensed dentist or licensed physician. Excluded dental charges are any charges for procedures in excess of the reasonable and customary charges, as defined as follows, and subject to the limitations on covered dental expenses and the exclusions herein. Reasonable and customary charge means the lowest of (i) the usual charge by the dentist or other provider of the services or supplies for the same or similar services or supplies; (ii) the usual charge of most other dentists or other provider of similar training or experience in the same or similar geographic area for the same or similar service or supplies, and (iii) the actual charge for the services or supplies.

For all Covered Expenses, the following services will be considered an integral part of the entire dental service rather than a separate service:

1. Local Anesthesia
2. Bases
3. Pulp Caps
4. Study Models/Diagnostic Casts
5. Treatment Plans
6. Nitrous Oxide
7. Irrigation

In general, depending on the type of coverage provided in this Plan (Type A, B, C or D), the following are Covered Expenses for Dental Benefits:

1. Cleaning (Prophylaxis), scaling and polishing procedures
2. Topical fluoride treatment
3. Sealants
4. Oral examinations
5. X-rays
    a. Intraoral complete series, panoramic film
    b. Bitewing films
    c. Other x-rays only to diagnose specific treatment
6. Amalgam and composite restorations
7. Space maintainers, fixed or removable, limited to initial appliance only and children under age 16
8. Recementation of inlays, onlays, crowns and bridges
9. Full and partial denture repair
10. Denture adjustments
11. Periodontics
    a. Periodontal scaling and root planing
    b. Periodontal surgery
    c. Periodontal maintenance
12. Surgical extractions
13. General anesthesia
14. Root canal therapy

15. Apicoectomy
16. Vital pulpotomy
17. Crowns, bridges, partial dentures and dentures
18. Denture relines or rebases
19. Occlusal guards and adjustments
20. Implants

Type A Expenses

- Oral examinations, not more than twice in a Benefit Year.
- X-rays - Bitewing x-rays, not more than twice in a Benefit Year;
  Full mouth x-rays, once in a thirty-six (36) month period (includes Panorex).
- Preventive treatment, consisting of:
  a. Oral prophylaxis - (cleaning and scaling of teeth), but not more than twice in a Benefit Year. Charges for oral prophylaxis for persons age thirteen (13) and younger are covered at the reasonable and customary charge for children.
  b. Topical fluoride treatment - available to Covered Persons under the fluoride treatment age shown in the Schedule of Benefits. Charges for topical fluoride treatments for persons age thirteen (13) and younger are covered at the reasonable and customary charge for children.
  c. Sealants – (materials, other than fluoride) - limited to one application every three (3) years on the occlusal surface of primary or permanent posterior teeth for Covered Dependents under age sixteen (16).
- Space maintainers, fixed or removable, limited to initial appliance only and children under age 16.
- Study models.

Type B Expenses

- Fillings
- Root Canal Therapy
- Oral Surgery
- Extractions
- Periodontal Treatment
- Emergency Palliation Treatment
- Occlusal guards and adjustments
- Administration of General Anesthetics: Benefits are provided only when medically necessary and/or administered in connection with oral surgery, or substances or agents which are administered to produce a state of sedation or relaxation or to reduce or eliminate pain while the patient is conscious.

Type C Expenses

- Inlays, onlays, crowns and dentures (except as a substitute to TMJ surgery)
- Repair or re-cementing of crowns, inlays, bridgework or dentures
- Periodontal surgical services
- Implantology

Type D Expenses

- Orthodontic treatment consisting of appliance therapy for Covered Dependent Children under the age shown in the Schedule of Benefits. No orthodontia services are provided for Covered Employees or Covered Spouses unless noted in the Schedule of Benefits.

Orthodontic Services: Necessary orthodontic services performed by a dentist (which are not considered Covered Dental Expenses under any other section of this benefit) provided that the total benefit payable for all orthodontics service expenses incurred by a Covered Person during any person's lifetime shall not exceed the Lifetime Maximum Benefit for Orthodontic Services set out in the Schedule of Benefits. The reasonable expenses for orthodontic services are subject to the Deductible and Copayment Provisions as shown in the Schedule of Benefits. Charges for orthodontic services performed prior to the effective date of a Covered Person's Dental Expense Benefits are not covered. An expense, for which the charge is made, will be deemed incurred on the date the service is rendered.

SPECIAL NOTE: In calculating the benefit payment for orthodontic services, the charge allowable for the initial fee will be limited to a maximum of one-third (1/3) of the total fee for the complete orthodontics treatment plan.

The payment of the balance of the orthodontics treatment plan will be reimbursed on a monthly or quarterly basis after the services have been rendered. The fee of only one orthodontist at a time will be allowed during one period of orthodontics treatment.

Exclusions

Expenses in connection with the following are not covered dental expenses unless specifically covered in the Schedule of Benefits:

1. Charges incurred for services rendered prior to the date coverage is effective or after coverage terminates.
2. Treatment other than by a licensed dentist or licensed physician except that scaling or teeth cleaning and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of a licensed dentist and the licensed dentist submits the claim.
3. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures and any service performed primarily to improve appearance.
4. Replacement of a lost, missing or stolen prosthetic device.
5. Replacement or repair of an orthodontics appliance.
6. Services rendered through a medical department, clinic or similar facility provided or maintained by the patient's employer.
7. Services or supplies for which no charge is made for which the patient is legally obligated to pay or for which no charge would be made in the absence of dental expense coverage.
8. Services or supplies which do not meet accepted standards of dental practice, or are not necessary according to those standards, including charges for services or supplies which are experimental or investigational in nature, and charges not yet approved by the Council of Dental Therapeutics of the American Dental Association.
9. Charges for dental disease, defect or injury resulting from war, declared or undeclared; or any act of war; invasion; hostilities; riot; rebellion; insurrection or aggression.
10. Any duplicate prosthetic device or any other duplicate appliance.
11. A plaque control program, i.e., a series of instruction on the care of the teeth.
12. Sealants: any material, other than fluorides, painted on the grooves of the teeth in an attempt to prevent further decay; and oral hygiene and dietary instruction or treatment except as may otherwise be covered as stated in the Schedule of Benefits.
13. Periodontal splinting.
14. Services to the extent that such services, or benefits for or because of such services, are otherwise provided under the Plan or under any other plan which the company or any subsidiary to or affiliated with the company contributes to or otherwise sponsors.
15. An appliance, or modification of one, where an impression was made before the patient was covered; a crown, bridge or gold restoration for which the tooth was prepared before the patient was covered under a dental plan approved by the supervisor of the Plan; root canal therapy if the pulp chamber was opened before the patient was covered. Charges for these services are deemed incurred on the date the impression was made, the date the tooth was prepared for a crown, bridge or gold restoration and on the date the pulp chamber was opened for a root canal.
16. Charges associated with the replacement of dentures, partial dentures, bridgework, or crowns not over five (5) years old.
17. Charges for services rendered for treatment of Temporomandibular Joint Dysfunction (TMJ), including surgery and x-rays.
18. Charges incurred for services or supplies which are furnished, paid for, or otherwise provided for by reason of the past or present services of any person in the armed forces of a government.
19. Charges for expenses in connection with either of the following:
    a. any condition for which a Covered Person has received or is entitled to receive, whether by settlement or by adjudication, any benefit under Workers' Compensation or Occupational Disease Law or similar law.
    b. Any occupational related injury or sickness.

    The provision of either a. or b. is set forth in the Schedule of Benefits under *Basis of Non-Occupational Coverage.*

20. Charges that would not have been made if no coverage existed or charges that a Covered Person is not required to pay.
21. Charges for the difference between the usual, customary and reasonable charges and the actual charges of the dentist or physician.
22. Charges for the services of any person who is a member of the Participant's immediate family or who ordinarily resides in the Participant's home.
23. Charges submitted after the claim filing period as set out in the Schedule of Benefits. Under certain circumstances, claims submitted after the claim filing period may be covered. See Claim Filing under Claims Review/Appeal Procedures.
24. Charges for services for a child who has exceeded the maximum age for coverage as a dependent child as set out in the Schedule of Benefits.
25. Charges received from a person or entity that does not meet the Plan's definition of a covered provider.
26. Charges in a claim that have been filed more than once.
27. Charges that represent amounts over-paid for previous charges for a claimant, which amounts have not been reimbursed to the plan.
28. Charges for which another health plan has primary responsibility for payment.
29. The amount of a charge that represents a discount allowed on the original claim from the provider.
30. Charges for surgical trays when used in a surgical procedure.
31. Charges for claims that the Plan Supervisor cannot process without additional information from the claimant or provider. See Necessary Documentation under APPEALING AN ADVERSE BENEFIT DETERMINATION/DENIED CLAIM.
32. Individual and family deductibles, if any, as set out in the Schedule of Benefits.
33. The amounts of claims that are billed using separate current dental terminology (CDT) codes for procedures or services that should have been included and billed under one CDT code for each procedure or service.
34. The amounts of claims that are billed using only one current dental terminology (CDT) code for more than one procedure or service that should have been billed using a separate CDT code for each procedure or service.
35. The amount of the discount allowed and not covered by the dental care plan that pays a claim as primary payor.
36. Charges for hospital calls made by a treating dentist.
37. Charges for therapeutic drug injections.
38. Charges for application of desensitizing medicament or application of desensitizing resin for cervical and/or root surface, per tooth.
39. Charges for fabrication of athletic mouthguards.
40. Charges for enamel microabrasion and external bleaching per arch or per tooth or internal bleaching per tooth.
41. Charges for infection control, sterilization fees, OSHA fees and disease prevention.
42. Charges for pontic - porcelain/ceramic fixed partial dentures.
43. Charges for inlay/onlay - porcelain/ceramic partial denture retainers.
44. Charges for retainer - porcelain/ceramic for resin bond fixed prosthesis.
45. Charges for the following crowns: porcelain/ceramic, ¾ cast predominately based metal, ¾ cast noble metal, ¾ porcelain/ceramic.
46. Charges for cast post as part of fixed partial denture retainers.
47. Charges for core build up for fixed partial denture retainers, including pins.
48. Charges for fluoride gel carriers/applicators.
49. Charges for intentional reimplantations, including splinting.
50. Charges for oral hygiene instruction.
51. Charges for unscheduled dressing changes by someone other than the treating dentist.
52. Charges for provisional intracoronal or extracoronal splinting procedures.
53. Charges for interim partial or complete maxillary or mandibular dentures, including impressions.
54. Charges for temporary crowns.
55. Charges for diagnostic photographs.
56. Charges for administration fees and claim filing fees.
57. Charges for duplicate x-rays related to post-operative treatment.
58. Charges for late charges or interest charges or for completion of forms or for missed appointments.

59. Charges for anesthesiologist charges filed separately from the oral surgeon's charges.
60. Charges for periodontal maintenance treatment more often than once every three (3) months.
61. Charges for full mouth x-rays or Panorex more often than specified in the Schedule of Benefits.
62. Charges for oral examinations/prophylaxis more often than specified in the Schedule of Benefits.
63. Charges for sealants, when covered by the Plan, in conjunction with a filling on the same tooth.
64. Charges for sealants, when covered by the Plan, for claimants over the maximum age set out in the Schedule of Benefits, or when the sealant is applied more often than specified in the Schedule of Benefits, or when the claimant has received the maximum number of applications allowed by the Plan as specified in the Schedule of Benefits.
65. Charges for toothbrushes or toothpaste.
66. Charges that exceed the Lifetime Maximum Benefit allowed by the Plan, if any, for the benefit provided for the Covered Person, as set out in the Schedule of Benefits.
67. Charges that exceed the Calendar Year Maximum for a benefit as set out in the Schedule of Benefits.
68. Charges for Lifetime Deductibles.
69. Charges for fluoride treatment unless included as covered in the Schedule of Benefits.
70. Charges for Type "B," Basic Service, coverage unless included as covered in the Schedule of Benefits.
71. Charges for Type "C," Major Service, coverage unless included as covered in the Schedule of Benefits.
72. Charges for Type "D," Orthodontic, coverage unless included as covered in the Schedule of Benefits.
73. Charges for fluoride treatment for claimants over the maximum age set out in the Schedule of Benefits.
74. Charges for a diagnosis or treatment that is inappropriate for the subject tooth.
75. Charges for a diagnosis or treatment that is inappropriate for the age of the claimant.
76. Charges for fluoride treatment billed separately from the prophylaxis charge when prophylaxis is covered.
77. Charges for periodontal treatment unless such treatment is set out as covered elsewhere in this Plan.
78. Charges for services or supplies or for treatment to teeth and gums that are not included under Covered Expenses in this Plan.
79. Charges for anesthesia other than general anesthesia.
80. Charges for modification of removable prosthesis following surgery.
81. Charges for maxillofacial prosthetics.
82. Charges for oral pathology laboratory procedures.
83. Charges for excision of bone tissue.
84. Charges for the treatment of simple or compound tooth fractures.
85. Charges for a procedure or treatment rendered before the end of the Waiting Period, if any.
86. Charges for claims incurred by Late Enrollees before the end of the Late Enrollee Waiting Period.
87. Charges for odontoplasty, including the removal of enamel projections.
88. Charges for repair procedures, including, but not limited to: skin grafts; osteoplasty; osteotomy; LeFort (I, II and III); frenulectomy; sialolithotomy; repair of maxillofacial soft and hard tissue defects; sialodochoplasty; emergency tracheotomy; coronoidectomy; synthetic grafts and osseous, osteoperiosteal or cartilage grafts; mandible implants for augmentation purposes and appliance removals by a dentist other than the one that placed the appliance.
89. Charges for surgical procedures, including, but not limited to: tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth and/or alveolus; tooth transplantation, including from one site to another and splinting and/or stabilization.
90. Charges for treatment to teeth or gums resulting from injury caused by an event that is external, violent, sudden and not foreseen, exact as to time and place and independent of all other causes.
91. Charges for services that are generally considered to be medical services, except those specifically listed in the Covered Expenses.
92. Charges for orthodontics, when orthodontics is covered under the Plan, for claimants not specifically covered, as set out in the Schedule of Benefits.

Proof of Claim

As part of the basis for determining benefits to be paid, the Plan Supervisor may require submission of x-rays and other appropriate diagnostic and evaluative materials. When these materials are unavailable and to the extent that verification of covered dental expenses cannot reasonably be made by the Plan Supervisor based on the information available, benefits for the course of treatments may be for a lesser amount than that which otherwise would have been paid.

Benefits After Cessation of Coverage

The Plan will not pay for services or supplies furnished after the date of cessation of coverage. However, benefits on account of covered dental expenses incurred for the following procedures will be paid as though the coverage had continued in force:

A prosthetic device, such as full or partial dentures, if the dentist took the impressions and prepared the abutment teeth while the patient was covered under the Plan and delivers and installs the device within two (2) months following cessation of coverage.

A crown if the dentist prepared the tooth for the crown while the patient was covered under the Plan and installs the crown within two (2) months following cessation of coverage.

Root canal therapy if the dentist opened the tooth while the patient was covered under the Plan and completes the treatment within two (2) months following cessation of coverage.

SPECIAL ALERTS TO COVERED PERSONS

1. Claims must be submitted to the Plan Supervisor within the claim filing period in the Schedule of Benefits. If your provider will file the claim with the Plan Supervisor, you should encourage the provider to submit the claim before the end of the claim filing period. ***Most important:*** with few exceptions, if a claim is not filed within the claim filing period, it will not be paid. **Fraud or Deceit:** Any intentional misstatement of a material and/or relevant fact by, or on behalf of, a Participant may result in enrollment being voided and/or denial of benefits.

2. Plan benefits are self-funded which means that the Employer has the ultimate responsibility for providing the benefits.

3. The Plan's benefits, including the determination of reasonable and customary charges, are paid using the Benefit Processing Guide shown in the Schedule of Benefits.

ERISA RIGHTS

CERTAIN ERISA REQUIREMENTS

This Summary Plan Description has been prepared to furnish you, the Participant, with information regarding the benefits to which you and your eligible dependents may be entitled under this Plan. The Employee Retirement Income Security Act of 1974 (ERISA) requires that all Participants be furnished a Summary Plan Description (SPD) of their benefit plan.

The Schedule of Benefits in this Summary Plan Description gives you this information and details about the benefits in your Plan. The objective of this Summary Plan Description is to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of the Summary Plan Description, please consult your Plan Supervisor.

The Terms and Phrases section identifies the Plan Name, Effective Date of the Plan, Type of Plan, Plan Year, the Plan Administrator, the Plan Supervisor, the Plan Trustees, if any, the Plan Coordinator and the required Plan

Numbers. The Employer shown under Terms and Phrases is also the Plan Sponsor. Benefits on behalf of named Participating Employers may also be provided through the Plan.

STATEMENT OF RIGHTS

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

- 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, if such report is required.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if required, and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report, if the plan is required to prepare such a report. Some plans, such as plans with fewer than one hundred (100) Participants, may not be required to prepare a summary annual report.

- Continue coverage for yourself, your 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.

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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (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 $110.00 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, and you disagree with the denial, you may appeal the denial by following the procedures under Appealing an Adverse Benefit Determination below. If your claim is still denied and you still disagree, you may file suite in a State or Federal Court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay Court costs and legal fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

OTHER ITEMS OF INTEREST

You receive no special employment rights from this Plan. The Employer shall have the sole and final authority to control, manage and determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The named Plan Administrator may delegate responsibilities for the operation and administration of the Plan to the Plan Supervisor. The Plan Administrator shall nominate a person or persons, referred to in the Schedule of Benefits as the *Plan Coordinator* to assist in day-to-day Plan matters. The Plan Administrator shall have the authority to amend the Plan and to determine its policies, to appoint Plan Supervisors, fix their compensation (if any), and exercise general administrative authority over them. Copies of amendments for any material reduction in covered services or benefits will be furnished to the Plan Participants no later than sixty (60) days after the adoption of the changes. The Plan Administrator has the sole authority and responsibility to review and make final decisions on Plan matters such as benefit adjudication, eligibility for coverage determinations and construing terms.

The Plan Administrator shall, in its sole discretion, interpret all Plan provisions and make all determinations as to whether any particular Covered Person is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of the Plan that is adopted by the Plan Administrator and for which there is a rational basis shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator shall be subject to review only if such interpretation or other action is without rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. If any eligible Employee who performs services for this Employer that are or may be compensated for in part by benefits payable pursuant to this Plan, such an Employee shall be treated as agreeing with and consenting to any decisions that the Plan Administrator makes, in its sole discretion, and further agrees to the limited standard of review described by this section by the acceptance of such benefits.

While the Plan is intended to be permanent, it may be amended or terminated by the Employer at any time. Any Plan Amendment shall be written, and shall indicate both the effective date of the change and the execution date of the amendment. You will be furnished a copy of the amendment. Plan benefits are legally enforceable. The Plan is maintained for the exclusive benefit of the Participants.

Overpayments, made in error, are recoverable by the Plan. Under facility of payment rules, payments may be made to persons to expedite payments and satisfy Plan liabilities. Plan liabilities will cease after a period of one year from the payment due date if persons are not found who are to receive such payments or if the benefit checks are not cashed within six (6) months of issue.

Plan benefits are not subject to anticipation, sale, pledge or attachment or similar alienation. You always have the right of free choice of providers. Your workers' compensation benefits are not affected by your Plan. Unless otherwise provided, coverage is not extended to retired or former Plan Participants. Benefits, participation or other requirements mandated by federal law or regulations will be provided by your Plan. Where misstatements occur, benefits or eligibility, incorrectly determined, will be redetermined using the correct information.

CLAIMS

FILING A CLAIM

1. Claims and bills will usually be submitted to ACS directly by your Provider.
2. In some instances, you will be required to file a claim form with the Plan Supervisor. When this becomes necessary, claim forms are available on the Human Resources web site, wfu.edu/hr, or in the Human Resources office.

3. Send the claim form or forms to the Plan Supervisor within the Claim Filing Period as stated in the Schedule of Benefits. Failure to do so may result in the Plan Supervisor denying your claim. Such denial may be reversed if circumstances justified such a delay.
4. After claims are submitted and determined to be payable, the Plan Supervisor will process and pay your claims within thirty (30) days of their approval. However, if there is to be a delay in paying such claims, the beneficiary will be given a written notice explaining this delay. Claim forms are available from your Plan Coordinator or the Plan Supervisor. As an administrative convenience, the Employer may request that you notify the Plan Supervisor directly and that you deal directly with them rather than with the Plan Coordinator. Benefits may be assigned at your request.

SOME IMPORTANT DO'S AND DON'TS

- Do be sure your enrollment form is filled in accurately, completely, legibly and timely.
- Do notify your Plan Coordinator of any changes in name, address, dependent status, etc.
- Do prepare the claim form completely and accurately using the form obtained from the Plan Coordinator, when a claim form is necessary or required.
- Don't submit duplicate bills.
- Don't send cancelled checks or cash register receipts.
- Don't wait until the end of the Benefit Year to send in expenses. Do send them in as soon as you receive them.
- Do file your claim within the Claim Filing Period as stated in the Schedule of Benefits.
- Do contact the Plan Supervisor if you have any questions. The Plan Supervisor, more than the Plan Coordinator, will be able to assist you with specific claims questions.
- Do allow six (6) weeks for payment of a claim from the date you mailed the claim. Don't call for status before the end of such six (6) week period.
- Don't send bills without including your name, your Employer name and the Plan number. If your dentist accepts an assignment, be certain that he or she knows the name of your Employer.

CLAIMS APPEAL PROCEDURES

The Plan's claims procedures vary depending on the type of claim filed. Claims may be any one of the following three (3) types of claims:

Pre-Service Claim - a Pre-Service Claim is a claim for dental care under the Plan for which prior approval for the care, in whole or in part, is a condition of receiving the dental care.
Concurrent Care Claim - a previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.
Post-Service Claim - a claim for dental care for which the dental care has already been received by the claimant.

In addition, a Pre-Service or Concurrent Care Claim may involve "Urgent Care." A Pre-Service or Concurrent Care Claim involving Urgent Care is one in which the application of the time period for making a determination of a Pre-Service Claim or Concurrent Care Claim will seriously jeopardize the life of the claimant (in the view of a prudent lay person acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's condition) or will subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition). **This Plan does not require prior approval for Emergency or Urgent Care Claims.**

In each situation below, "the claimant" includes a third party representative who has been authorized to file claims on behalf of the claimant in accordance with the Plan's internal policies and procedures. In the case of an Urgent Care Claim, the health care professional with knowledge of the claimant's condition will always be considered an authorized representative.

Pre-Service Claim

If the claimant submits a Pre-Service Claim, the claimant will be notified of the benefit determination (whether adverse or not) within a reasonable period of time but not later than fifteen (15) days after the Plan Supervisor's receipt of the Pre-Service claim. This period may be extended one time for up to fifteen (15) days for reasons beyond the control of the claims reviewer if the claimant is notified, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If an extension is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be given at least forty-five (45) days from receipt of the notice to provide the specified information. If the claimant fails to properly submit the claim in accordance with the Plan's procedures for filing a claim, the claimant will be notified orally or in writing within five (5) days of the date that the claimant attempted but failed to properly file a claim in accordance with the applicable rules and regulations and given instructions on how to properly file a claim.

Urgent Care Claim (Pre-Service)

Except as provided below, if the claimant submits a Pre-Service Claim that is also an Urgent Care Claim, the claimant will be notified of the claims reviewer's benefit determination (whether adverse or not) as soon as possible, but not later than seventy-two (72) hours after the claims reviewer receives the claimant's claim. If the claimant fails to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the Plan, the claimant will be notified as soon as possible, but not later than twenty-four (24) hours after receipt of the claims reviewer's receipt of the claimant's Urgent Care Claim by the Plan, of the specific information necessary to complete the claimant's Urgent Care Claim. The claimant will be provided forty-eight (48) hours to provide the specified information. The claimant will be notified of the claims reviewer's benefit determination as soon as possible but no later then forty-eight (48) hours after the earlier of (i) the receipt of the requested information, or (ii) the end of the forty-eight (48) hour period, whichever occurs first. If the claimant fails to properly submit the claim in accordance with the Plan's procedures for filing a claim, the claimant will be notified orally or in writing within twenty-four (24) hours of the time that the claimant attempted but failed to properly file a claim in accordance with the applicable rules and regulations and given instructions on how to properly file a claim.

Concurrent Care Claim

If an ongoing course of treatment has been approved under the terms of the Plan, any reduction or termination of the claimant's ongoing course of treatment (other than by Plan Amendment or Plan termination) before the end of such course of treatment is an adverse benefit determination. The claimant will be notified of any determination to reduce or stop the ongoing course of treatment within a reasonable amount of time prior to the reduction or termination to allow the claimant to appeal and obtain a determination prior to the effective date of the reduction or termination of the claimant's ongoing course of treatment.

If the claimant requests to extend an ongoing course of treatment beyond the period of time or number of treatments originally approved and the claimant's request involves an Urgent Care Claim, the claimant will be notified of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claimant's claim by the claims reviewer, provided that the claimant's claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the ongoing course of treatment. If the last day of approved ongoing treatment falls on a Saturday, Sunday or Monday of a regular work week or the first through last day of a business holiday or the first business day after a business holiday, this Plan does not require prior approval to extend such ongoing treatment through the next business day.

Post-Service Claim

If the claimant submits a Post-Service Claim that is denied in whole or in part, the claimant will be notified within a reasonable period of time but not later than thirty (30) days after receipt of the claimant's claim. This period may be extended up to fifteen (15) days if an extension is necessary due to matters beyond the control of the claims reviewer and the claimant is notified, prior to the end of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which a decision will be rendered. If an extension is necessary due to the claimant's failure to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information that is missing, and the claimant shall be provided at least forty-five (45) days from receipt of the notice to provide the specified information.

The period of time within which a benefit determination is required to be made shall begin at the time the claimant's claim is filed. A claim is properly filed when submitted electronically or by mail to the address on the claimant's I.D. card and received by the Plan Supervisor. If the period of time to make a benefit determination is extended due to the claimant's failure to submit information necessary to decide a claim other than an Urgent Care Claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the claimant until the claimant responds to the request for additional information, whichever is earlier.

NOTICE OF BENEFIT DETERMINATION

If the claimant's claim is denied in whole or in part (or for Pre-Service Claims or claims involving Urgent Care, if the claimant's claim is approved), the claims reviewer will provide the claimant with a written or electronic notification setting forth the following information:

1. The specific reason or reasons for the denial;
2. The specific provisions of the Plan on which the denial is based;
3. A description of any additional material or information necessary for the claimant to perfect the claimant's claim, together with an explanation as to why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review;
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such a rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to the claimant upon request.
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. If the claim was an Urgent Care Claim, a description of the expedited review process applicable to such claims.

If the claimant's Urgent Care Claim was denied in whole or in part, the notice may be provided to the claimant orally; however, a written or electronic notification will be provided to the claimant not later than three (3) days after the oral notification.

APPEALING AN ADVERSE BENEFIT DETERMINATION/DENIED CLAIM

If the claimant's claim for benefits other than a Concurrent Care Claim has been denied in whole or in part by the claims reviewer, the claimant may file an appeal with the Plan Supervisor within one hundred eighty (180) days of the denial. If you do not file your appeal within one hundred eighty (180) days of the denial, you will lose your right to file suit in court about the denial. The claimant will be notified of the time period in which the claimant must file an appeal of an adverse benefit determination for a Concurrent Care Claim. After the claimant appeals an adverse benefit determination, the Plan Supervisor will:

1. Provide to the claimant the opportunity to submit written comments, documents, records and other information relating to the claimant's claim for benefits;
2. Provide that the claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
3. Provide for a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claimant's claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal or the subordinate of such individual;

5. Provide that, in deciding an appeal of an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional may not be 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;
6. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
7. Provide, in the case of an Urgent Care Claim, for an expedited review process pursuant to which (i) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant and (ii) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the claimant and the Plan by telephone, facsimile or other available similarly expeditious methods.

The period of time within which a benefit determination on review is required to be made varies by the type of claim. Notwithstanding the type of claim, the time period for making a determination will begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing.

Pre-Service/Concurrent Care Claim

In the case of a Pre-Service Claim or Concurrent Care Claim, the Plan Administrator will notify the claimant of the Plan's benefit determination on review not later than thirty (30) days after receipt by the Plan Administrator of the claimant's request for review of an adverse benefit determination.

Urgent Care Claim

In the case of an appeal of an adverse benefit determination for a Pre-Service or Concurrent Care Claim that is an Urgent Care Claim, the Plan Supervisor will notify the claimant of the Plan's benefit determination on review not later than seventy-two (72) hours after receipt by the Plan Administrator of the claimant's request for review of an adverse benefit determination by the Plan.

Post Service Claim

The Plan Supervisor will notify the claimant of the Plan's benefit determination on review within a reasonable time, but not later than sixty (60) days after receipt by the Plan Administrator of the claimant's request for review of an adverse benefit determination.

NOTICE OF BENEFIT DETERMINATION

Notice of Adverse Benefit Determination Upon Review

The Plan Administrator will provide the claimant with written or electronic notification of the Plan's benefit determination on review. If the claimant's claim is denied on review, the Plan Administrator shall provide the claimant with a written or electronic notification setting forth the following information:

1. The specific reason or reasons for the denial;
2. The specific provisions of the Plan on which the denial is based;
3. A statement that the claimant 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 claimant's claim;
4. A statement describing the Plan's voluntary appeal process, if any;
5. If an internal rule, guideline or protocol was relied upon in making the denial, a statement that such rule, guideline or protocol was relied upon in making the denial and that a copy of such rule, guideline or protocol will be provided free of charge to the claimant upon request;
6. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

7. A statement that the claimant and the Plan may have voluntary alternative dispute resolutions options available.

Miscellaneous Information Regarding Claims

Necessary Documentation - The Plan Supervisor (ACS) occasionally will need information and documentation in addition to the actual claim for benefits in order to be able to process and approve a claim. This information and documentation may be in the possession of the claimant, the health care provider or the employer. If the necessary documentation is not submitted with the claim, ACS will deny the claim with an explanation of what further information or documentation is required. If an ACS form is the documentation that is required, a copy of that form will be included with the denial. Such information and documentation may include, but is not limited to the following: surgical notes; a claim form (Benefit Submission Form); accident details/third party liability information; an itemized bill; complete orthodontic plan; dates of procedures and other significant dates; full-time student verification information; assignment of benefits; documentation of other coverage; medical records; diagnosis or diagnosis code; documentation of medical necessity; physician's office notes; provider's credentials, name, address, tax identification number; physician's signature; physician's release to return to work; documentation of financial dependency of children. All necessary ACS forms are available on the ACS website at www.acsbenefitservicesinc.com.

Two (2) Levels of Appeals

The Plan Administrator may, in its sole discretion, require two (2) levels of mandatory appeals following an initial adverse benefit determination of any claim other than an Urgent Care Claim. If so, the claimant will be notified of the procedures for filing the first level of appeal. Each level of appeal is subject to the same rules and regulations described above with respect to Appeals of An Adverse Benefit Determination except that the claimant will not have one hundred eighty (180) days in which to file the claimant's second level of appeal. The claimant will be notified of the time frame for filing a second appeal. In addition, the time period during which a determination must be made for one appeal will be split evenly for each level of appeal.

Disability Determination

If the Plan offers an extension for those Participants on the basis of disability (as set forth in the Schedule of Benefits) and the Plan Supervisor is responsible for making the determination as to whether a Participant is indeed disabled, the following different rules apply to the disability determination:

- The claims reviewer will notify the claimant of an adverse benefit determination within forty-five (45) days of receipt of the claim. The claims reviewer may take two (2) extensions of thirty (30) days each if for reasons beyond the control of the claims reviewer.
- The claimant will have one hundred eighty (180) days in which to appeal the adverse benefit determination to the Plan Administrator.
- The Plan Supervisor will notify the claimant of an adverse benefit determination within forty-five (45) days of the date the Plan Supervisor received the appeal. The Plan Administrator may take a forty-five (45) day extension if for reasons beyond the control of the Plan Administrator.

ELIGIBILITY GENERALLY

WHEN ARE YOU AND YOUR DEPENDENTS ELIGIBLE?

The Eligibility for This Plan section lists which Employees or Employee classes are eligible for coverage, the Eligibility Waiting Period, the Qualifying Hours you must work during the Eligibility Waiting Period, and the Minimum Hours per week you must work to be considered Actively-at-Work.

As a new employee of an Eligible Class, as shown in the Eligibility for This Plan section, upon timely completion of an enrollment form, your coverage will begin at the end of the Eligibility Waiting Period. If you are transferred here from another country, you will be treated, for enrollment purposes, as if your hire date is the day you are scheduled

to begin work here. If you were covered by a plan sponsored by the Employer on the day before ACS became Plan Supervisor, upon timely completion of an enrollment form, you are automatically covered under this Plan.

You must complete an enrollment form within thirty (30) days of becoming eligible. If you do not apply when first eligible, you may apply for coverage at a later date if (a) you satisfy the Special Enrollment Rules of this plan; (b) this Plan offers an Annual Enrollment or; (c) if this Plan permits Late Enrollment. If you fail to apply for coverage on a timely basis, you will be a *Late Enrollee*. Your dependents become eligible for coverage when you do. If any dependent is not enrolled when first eligible, the same rules about applying for coverage at a later date apply. If your dependents are residents of a foreign country at the time you first become eligible for coverage, you may enroll them later provided you apply for coverage within thirty (30) days of when they join you in this country. The effective date of coverage for such dependents will be the first day of the month following written application or the day coverage becomes effective for the Employee, whichever is later.

If you lose coverage due to a COBRA qualifying event other than termination of employment and later become eligible for coverage again, you may re-enroll in the Plan. In such cases, you must re-enroll for coverage within thirty (30) days of again becoming eligible for coverage. If you elected and maintained COBRA coverage when you lost eligibility, your new effective date of coverage will be the day following the day you submit your written application. If you did not elect COBRA when you lost eligibility, your new effective date of coverage will be the first day of the month following your written application.

If your Plan has a re-enrollment period, as indicated in the Eligibility for This Plan section, the Eligibility Waiting Period is waived if your employment is terminated and you are then rehired within the Re-Employment Period, if any, shown in the Eligibility for This Plan section. If you were covered under COBRA during the period between your termination and being rehired, coverage is effective on the day you are rehired if you enroll within thirty (30) days. If you were not covered under COBRA during this period, coverage is effective the first day of the month following your written application within thirty (30) days of your Re-Employment.

Coverage for newly acquired dependents is not automatic. Newly acquired dependents must be timely enrolled under the Special Enrollment Rules for coverage to be effective as a Special Enrollee. To timely enroll new dependents, you must apply within thirty (30) days of the date of eligibility (date of marriage, date of birth, date of adoption, date child is placed for adoption, date of custody of a foster child or the date the step-child(ren) come to live with you). Such thirty (30) day period is extended to ninety (90) days for a dependent child or spouse in cases in which the addition of such dependent does not affect the Employee's contribution to the Plan. (For example, if the Plan does not require any Employee contributions for single or family coverage or if the employee is already paying for family coverage). If coverage for a dependent is applied for more than thirty (30) days (or more than ninety (90) days where the Employee's contribution does not change) following the date of such dependent's eligibility for coverage, the dependent will be a *Late Enrollee*.

Your Plan will provide coverage for any of your dependent children for whom there is a Qualified Medical Child Support Order, or other Court Order, as mandated by federal statutes. The Plan Sponsor determines whether the Employee/parent must also enroll in the Plan when a Qualified Medical Child Support Order is in effect. The effective date of coverage for a Qualified Medical Child Support Order Alternate Recipient is the date that all the necessary documentation is received and processed by the Plan Supervisor or the initial effective date of the Employee/parent, whichever is later. Even if the Plan does not require the Employee/parent to be a Plan Participant, the eligibility of the Qualified Medical Child Support Order Alternate Recipient terminates when the Employee/parent loses eligibility under the Plan. A copy of the Plan's procedures for processing Qualified Medical Child Support Orders may be obtained from the Plan Administrator at no charge. Also, coverage for your adopted child or child placed for adoption may be provided on the date of adoption or the date of placement for adoption. Coverage for a foster child may be effective on the first day of the first calendar month beginning after the date sufficient evidence (as determined by the Plan Administrator or Plan Supervisor) has been received demonstrating that the child is an eligible dependent, but no earlier than the date you obtained custody of the child. Application for such coverage must be timely and properly made.

Employees of the Plan Sponsor or a Participating Employer who are transferred, either internally or physically, between divisions of the Employer or between Participating Employers may enroll in this Plan and receive credit against the Eligibility Waiting Period for time employed at the prior division or Participating Employer.

A Covered Dependent of a Participant who becomes eligible for coverage under this Plan as an Employee and elects coverage shall receive credit against the Eligibility Waiting Period, if any, for the time covered as a dependent prior to his or her Enrollment Date. Likewise, an otherwise eligible dependent spouse may become eligible for coverage under this Plan as if he or she had become eligible for the first time and not as a *Late Enrollee* in those cases where the spouse has lost coverage under this Plan due to loss of eligibility as an employee, with credit against the Eligibility Waiting Period, if any, for the time since his or her Enrollment Date as an employee.

SPECIAL ENROLLMENT RULES

For Individuals Losing Other Coverage

If you declined enrollment (coverage) for yourself or your eligible dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and your dependents in this Plan, provided you request enrollment (coverage) within thirty (30) days after the other coverage ends. For purposes of Special Enrollment under this Plan, other coverage includes Medicaid, Medicare, coverage for members of the uniformed services, coverage under a State health benefits risk pool, coverage under the Federal Employees Health Benefits Program, coverage under the State Children's Health Insurance Program and any health coverage plan established or maintained by a State, the United States government, a foreign country, or any political subdivision of a State, the U.S. government or a foreign country. **Each** of the following conditions must be met:

1. You or your eligible dependent was covered under a group dental plan or had dental insurance coverage at the time coverage under this Plan was previously offered to the individual and such coverage was:
   a. under a COBRA continuation provision and the coverage under such provision was *exhausted* (this Plan requires that COBRA coverage be exhausted before enrollment as a *Special Enrollee* unless otherwise specified under Eligibility for This Plan). *Exhaustion* of COBRA continuation coverage means that an individual's COBRA continuation coverage ceases for any reason other than either (i) failure of the individual to pay premiums on a timely basis, or (ii) for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan. An individual is considered to have *exhausted* COBRA continuation coverage if such coverage ceases (a) due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or (b) when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual, or
   b. not under a COBRA continuation provision and the coverage was terminated as a result of either:
      (i) *loss of eligibility* for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any *loss of eligibility* after a period that is measured by reference to any of the foregoing. Thus, for example, if your coverage terminates following a termination of employment and you are eligible for but fail to elect COBRA continuation coverage, this is treated as a *loss of eligibility*); *loss of eligibility* also means loss of coverage due to loss of dependent status and any other event as determined by the Plan Administrator; *loss of eligibility* does not include a loss of coverage due to failure of the individual (employee or dependent) to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan); or
      (ii) employer contributions towards such coverage were terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual. Loss of eligibility will also include the following situations:
         (a) In the case of coverage through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual);

(b) In the case of coverage through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(c) Where an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;

(d) Where a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

2. You apply for coverage no later than thirty (30) days after the date of: (a) exhaustion of COBRA coverage; (b) termination of coverage due to *loss of eligibility* for the coverage; (c) termination of employer contributions towards such coverage; or (d) the date a claim is denied due to meeting or exceeding a plan's lifetime limit on all benefits. If coverage for an individual is applied for more than thirty (30) days following the date the individual became eligible under these Special Enrollment Rules, the individual will be considered a *Late Enrollee*.

Loss of eligibility under another group health plan in the following circumstances shall make the affected person eligible for enrollment as a *Special Enrollee*: in those situations where an employee and/or dependent drops coverage under this Plan in order to take coverage under another comparable group plan. All other Special Enrollment rules shall apply.

An otherwise eligible dependent spouse and dependent children may become eligible for coverage under this Plan as if they had become eligible for the first time and not as *Late Enrollees* in those cases where the spouse and children have lost coverage under the Plan due to legal separation and the spouse later reconciles with the covered employee. In such cases, the dependent spouse and children shall have thirty (30) days from the date of the reconciliation to enroll in the Plan, and the effective date of coverage shall be the date of enrollment. Any such dependent spouse and children who do not enroll within thirty (30) days shall be *Late Enrollees*.

Persons Eligible to Enroll as Special Enrollees After Losing Other Coverage

1. When the employee loses other coverage and all the Special Enrollment rules above apply, the otherwise eligible employee, spouse and any dependent children may enroll in the Plan.
2. When an otherwise eligible spouse or dependent child(ren) loses other coverage and all the Special Enrollment rules above apply, the employee may enroll but only the spouse or dependent child who lost coverage may enroll. Other dependents may not enroll as *Special Enrollees*.

   In the situations described in 1. and 2., any of these *Special Enrollees* may enroll in any benefit package available, even if the employee was already enrolled in a benefit package.

Effective Date of Coverage for Special Enrollees Who Lost Other Coverage

Unless otherwise specifically noted under Eligibility for This Plan, the effective date of coverage for *Special Enrollees* who become eligible due to loss of other coverage shall be the first day of the next calendar month following written application.

For Newly Acquired Dependents

If you have a new dependent as a result of marriage, birth, adoption, placement for adoption, obtaining custody of a foster child or having a step-child(ren) come to live with you, you may enroll yourself, if not already covered, your spouse and your new dependent child(ren), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, placement for adoption, obtaining custody of the foster child or having a step-child(ren) come to live with you. Other dependent children that you already have are not eligible to be enrolled under this provision. When new dependents are acquired as a result of marriage, birth or adoption, the effective date of coverage for you and your spouse and any such newly acquired dependent child(ren) who are properly enrolled shall be the date of the marriage, birth, adoption or placement for adoption. When new dependents are acquired as a result of obtaining custody of a foster child or a step-child coming to live with the Participant, the effective date of coverage for your spouse and your foster child or your spouse and step-child(ren) shall be the first day of the month

following the date that sufficient evidence has been received to determine that the child is an eligible dependent, but no earlier than the date the Participant obtained custody of the child or the date the step-child(ren) come to live with you. In any case, the effective date of coverage shall not be earlier than the date the Participant would be eligible for coverage, according to the Eligibility for This Plan section.

If coverage for an individual is applied for more than thirty (30) days following the date the individual became eligible under these **Special Enrollment Rules**, the individual will be considered a *Late Enrollee*. See the Eligibility for This Plan section to determine if this Plan allows *Late Enrollment.*

Effective Date of Coverage for Newly Acquired Dependent Special Enrollees

1. **Marriage** - The *Effective Date of Coverage* shall be the date of marriage.
2. **Birth** - The *Effective Date of Coverage* shall be the date of birth of the child.
3. **Adoption or Placement for Adoption** - The *Effective Date of Coverage* shall be the earlier of the date of adoption or placement for adoption. This includes a child born of a surrogate mother.
4. **Foster Child** - The *Effective Date of Coverage* shall be the first day of the first calendar month beginning after the date sufficient evidence has been received to determine that the child is an eligible dependent but no earlier than the date the Employee obtained custody of the child.
5. **Step-Child** - The *Effective Date of Coverage* for a step-child(ren) of an Employee who comes to live with the Employee after the Employee's initial eligibility date shall be the first day of the first calendar month beginning after the date sufficient evidence has been received to determine that the child(ren) is an eligible dependent but no earlier than the date the step-child(ren) come to live with the Employee.

If the Effective Date of Coverage, as set forth above in "1." through "5.," is earlier than the Employee's completion of the Eligibility Waiting Period, the Effective Date of Coverage will be the date the Employee has met any applicable waiting period under the Plan, provided the Employee is eligible to be enrolled (covered) under the Plan but for a failure to enroll during a previous enrollment period. With respect to an adopted child, or a child placed for adoption, no maternity expenses associated with the birth of such a child will be covered under this Plan unless the birth mother is a covered Participant or a covered spouse.

WHO MAY BE A DEPENDENT?

In general, your spouse (if not legally separated from you) and your unmarried children may be dependents. A child must be under the Unmarried Child's Eligibility Age or a full-time student in high school, an accredited school, college or university (unless being a student is not required in the Schedule of Benefits), and must be principally dependent upon the Participant for financial support. A child will be presumed to be principally dependent on you for financial support if such child is claimed as a dependent for federal income tax purposes. Regardless of age, a physically or mentally disabled child may be a dependent if satisfactory proof of condition is provided and approved by the Plan Supervisor and if so indicated under Eligibility for This Plan.

The Eligibility for This Plan section shows the Unmarried Child's Eligibility Age and the maximum age for children who are in school full-time (if being a student is required). Your adopted child, child placed for adoption, step or foster child may be covered if financially dependent on you as evidenced by appropriate documentation as required by the Plan Sponsor.

Dependent status, once lost, may be reacquired in the following manner: for dependent children who are not covered by the Plan because either:

a. they were previously covered under the Plan and lost coverage because they exceeded the eligibility age and did not remain in school; or
b. they were already over the eligibility age when coverage was first available.

Such dependent children may become covered under the Plan if they become full-time students before reaching the extended eligibility age set out under Eligibility for This Plan (if the Plan provides for an extended eligibility age) and if they apply for coverage within thirty (30) days of the first day of full-time student status. The effective date of coverage for any such dependent child who reacquired dependent status while covered as a COBRA participant as

a result of losing coverage under this Plan due to exceeding the eligibility age shall be the first day he or she becomes a full-time student or the day the enrollment application is submitted, whichever comes later. The effective date of coverage for any such dependents who reacquire dependent status but are not covered under COBRA with this Plan shall be the first day of the next month after the day they become full-time students or the first day of the next month after the day the enrollment application is submitted, whichever comes later.

In those situations where a dependent child who was eligible but was not enrolled when he or she was under the Unmarried Child's Eligibility Age and is now over the Unmarried Child's Eligibility Age but is still younger than the extended eligibility age (if any) provided under Eligibility for This Plan, such child may be enrolled in the Plan if he or she becomes a full-time student but only if the Plan allows Late Enrollment or if enrolled during an Annual Enrollment Period, if any.

WHEN DOES COVERAGE TERMINATE?

Your coverage terminates: when the Employer terminates the Plan; on the last day of the month in which your employment is terminated for any reason; when you change to an employee class that is not eligible for coverage; when you fail to meet the active-at-work requirements (except for extension of benefits coverage); or when you fail to make a required contribution to the Plan. The Plan may provide for extended coverage while you are on an employer approved leave of absence or while you are disabled. See Eligibility for This Plan.

WHAT ARE THE PLAN BENEFITS?

The Schedule of Benefits sets forth the Deductible Amount, the Plan Copayment Rate, Maximum Amounts, dollar benefits (those not subject to deductible and copayments) and those expenses which are covered. The deductible is determined by the Benefit Year as set out under Terms and Phrases.

HOW DOES THE DEDUCTIBLE AMOUNT WORK?

Many Plans have Individual and Family Deductibles. These amounts must be paid by the Covered Person before the Plan begins to pay. If this Plan includes deductibles, the amounts are set out in the Schedule of Benefits.

EXTENSION OF COVERAGE PROVISIONS

Your coverage ceases when you fail to meet the actively-at-work requirement but are still an Employee unless either one of the following two (2) conditions is met:

1. *Required Extension* - If your Employer is subject to the Family and Medical Leave Act and you are away from work on a leave under the Act, your coverage under this Plan will be continued as long as you continue on the Family or Medical Leave and as long as you continue to pay any required premiums.
2. *Discretionary Leave* - The Employer may extend your coverage for a period not to exceed the maximum leave of absence or as a discretionary leave of absence, such as for layoffs, as set forth in the Schedule of Benefits. Such leave must be evidenced by a written intention such as an Employer board resolution, a letter signed by an Employer's officer or a similar document.

The above-cited extensions also include your covered dependents, if any. These coverage extensions are terminated if for any reason your employment is terminated or the Plan is terminated. See COBRA rights.

REASONABLE AND CUSTOMARY GUIDELINES

The Plan Supervisor will review all charges and reduce any such charges that exceed reasonable and customary charge guidelines. Such guidelines are provided by any of several nationally recognized standards. Such standard is

indicated as the Benefit Processing Guide in the Terms and Phrases section. Where such standards are applied, the disallowed portion is not deemed to be a Covered Expense. Where appropriateness or medical necessity is determined, the primary guide of the Plan Supervisor shall be the Benefit Administration Manual set forth under Terms and Phrases.

USERRA

BACKGROUND

The Uniformed Services Employment and Re-Employment Rights Act of 1994 ("USERRA") established requirements that employers must meet for certain employees who are involved in the Uniformed Services (defined below). In addition to the rights that you have under COBRA (described in the section on COBRA), you are entitled under USERRA to continue the coverage you had under this Plan.

YOU HAVE RIGHTS UNDER BOTH COBRA AND USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the COBRA section (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage. COBRA and USERRA coverage run concurrently.

DEFINITIONS

"*Uniformed Services*" means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training or full-time National Guard duty), and the commissioned corps of the Public Health Service. Moreover, the President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

"*Service in the Uniformed Services*" or "*Service*" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, inactive duty training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

DURATION OF USERRA COVERAGE

General rule: 24 month maximum. When a covered person takes a leave for Service in the Uniformed Services, USERRA coverage for the employee (and covered dependents for whom coverage is elected) begins the day after the employee (and covered dependents) lose coverage under the Plan, and it continues for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.

COBRA and USERRA coverage are concurrent. This means that both COBRA coverage and USERRA coverage begin upon commencement of the employee's leave, and COBRA coverage continues for up to eighteen (18) months while USERRA coverage continues for up to twenty-four (24) months, up to six (6) months longer than COBRA.. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section. For example, George takes a leave of absence for service in the Uniformed Services beginning on August 1, 2006. George elects COBRA/USERRA continuation coverage and pays the required one hundred two percent

(102%) of the premium each month for the next eighteen (18) months. Although George's COBRA coverage would terminate at the end of this eighteen (18) month period, USERRA coverage could continue for another six (6) months, unless coverage is terminated earlier due to non-payment of premiums or other permitted event.

PREMIUM PAYMENTS FOR USERRA CONTINUATION COVERAGE

If you elect to continue your health coverage (or your spouse or dependent children's coverage) pursuant to USERRA, you will be required to pay one hundred two percent (102%) of the full premium for the coverage elected (the same rate as COBRA). However, if your Uniformed Service leave of absence is less than thirty-one (31) days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

HIPAA PRIVACY COMPLIANCE

IN GENERAL

Certain members of the Plan Sponsor's workforce have access to the individually identifiable health information of Plan Participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Plan.

> *Protected Health Information.* Protected Health Information means information that is created or received by the Plan and relates to the past, present or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected Health Information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this HIPAA Privacy Compliance section or as otherwise required or permitted by HIPAA.

PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

Permitted Disclosures of Enrollment/Dis-enrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan or is enrolled in or has dis-enrolled from the Plan.

Permitted Uses and Disclosures of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending or terminating the Plan.

"Summary Health Information" means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor had provided health benefits under a health plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Permitted and Required Uses and Disclosures of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law and subject to the conditions of disclosure described in the next section and obtaining written certification pursuant to the "Certification of Plan Sponsor" section, the Plan may disclose PHI to

the Plan Sponsor provided the Plan Sponsor uses or discloses such PHI only for Plan Administration purposes. "Plan Administrative purposes" means administrative functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring as well as investigating the payment of claims on behalf of and at the request of a Member of the Plan. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

Conditions of Disclosure for Plan Administrative Purposes

Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall:

a. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
b. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
d. Report to the Plan any use or disclosure of the information of which it becomes aware that is inconsistent with the uses or disclosures that are permissible;
e. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;
f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
g. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;
h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
j. Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall") required in 45 CFR § 504(f)(2)(iii) is satisfied.

The Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the Plan, it will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI, and it will ensure that any agents (including subcontractors) to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information. The Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall allow the Privacy Official and designated Persons in the Human Resources, Benefits and Accounting Departments and their supervisors access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administrative functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this section, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination

procedures. The Plan Sponsor will insure that the provisions of this Section are supported by reasonable and appropriate security measures to the extent that the designees have access to elective PHI.

Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in the above section "Conditions of Disclosure for Plan Administration Purposes."