

PLAN DOCUMENT

DENTAL PLAN



WAKE FOREST
UNIVERSITY

Administered By:

AS Benefit Services, Inc.
It's Time for a Better Health Plan

8025 North Point Blvd., Suite 100
Winston-Salem, NC 27106

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SCHEDULE OF DENTAL 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 – Type A, B, & C Services ONLY	\$1,500	
Low Option – Type A & B Services ONLY		\$500

Benefit Year is January 1st through December 31st.

Not Subject to Deductibles

Type A (Preventive) – Plan Coinsurance Rate	100%	100%
Fluoride Treatment for Dependent Child to Age	19	19
Type D (Orthodontics) – Plan Coinsurance Rate	50%	No Coverage
Maximum Lifetime Benefits for Orthodontics Only	\$1,500	No Coverage
Lifetime Deductible	None	No Coverage
Orthodontics For Employee, Spouse, & Dependent Children	Yes	No Coverage

Subject to Deductibles

Type B (Basic Service) – Plan Coinsurance Rate	80%	80%
Type C (Major Service) – Plan Coinsurance Rate	50%	No Coverage

Coordination of Benefits (COB) for Dental means 100%. Coordination of benefits for dependent Children is based on the birthday rule.

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 Benefit for orthodontics is 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 termination High Option Coverage.

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. No more than the applicable maximum Benefit Year dental benefit will be paid for expenses incurred for any Covered Person in a Benefit Year. No 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.

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, scaling and polishing of teeth), but not more than twice in a Benefit Year. Charges for oral prophylaxis for persons up to age thirteen (13) are covered at the reasonable and customary charge for children.
 - b. Topical fluoride treatment - available to Covered Children up to age thirteen (13), but not more than twice in a Benefit Year.
 - c. Sealants – (materials, other than fluoride) - available to Covered Children up to age sixteen (16), limited to one application every three (3) years on the occlusal surface of primary or permanent posterior teeth.
- Space maintainers, fixed or removable, limited to initial appliance only and children under age sixteen (16).
- Study models.
- Diagnostic photos.

Type B Expenses

- Fillings (amalgam, silicate, resin or composite)
- Periodontal Treatment
 - a. Scaling and root planing
 - b. Periodontal prophylaxis
 - i. Probing
 - ii. Charting
 - iii. Exam
 - iv. Polishing
 - v. Scaling
 - vi. Root planing
 - vii. Similar maintenance procedures
- Root Canal Therapy
 - a. Apexification
 - b. Apicoectomy
 - c. Retrograde filling
 - d. Root resection
 - e. Hemisection
 - f. Vital pulpotomy
- Occlusal guards (not TMJ related)
- Therapeutic drugs injections
- Harmful habit appliance for grinding of teeth
- Oral Surgery (including wisdom teeth)
 - a. Extractions – simple non-surgical and surgical
 - b. Surgical incision and drainage of dental abscess
 - c. Surgical exposure to aid eruption
 - d. Excision of hyperplastic tissue
 - e. Removal of dental cysts and tumors
 - f. Biopsy of oral tissue
- Emergency Palliation Treatment

Type C Expenses

- Inlays, onlays, crowns and dentures (except as a substitute to TMJ surgery).
- Repair or re-cementing of inlays, onlays, crowns, bridgework or dentures.
- Stainless steel crowns.
- Periodontal surgical services
 - i. Gingival flap procedures
 - ii. Gingivectomy
 - iii. Gingival curettage
 - iv. Osseous surgery
 - v. Pedicle soft tissue graft
 - vi. Free soft tissue graft
 - vii. Periodontal splinting
- Implants

Type D Expenses

- Orthodontic treatment consisting of appliance therapy for Covered Children under age nineteen (19). 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 orthodontic 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 will be allowed during one period of orthodontics treatment plan.

Exclusions

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

1. Charges incurred for services rendered prior to the effective date of coverage or after coverage terminates.
2. Charges for 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. Charges for services or supplies that are cosmetic in nature, including charges for veneer facings, personalization or characterization of dentures and any service performed primarily to improve appearance.
4. Charges for replacement of a lost, missing or stolen prosthetic device or appliance are not covered, provided, however, that charges for the replacement of crowns, bridgework, inlays and onlays, partial dentures and dentures are covered after five (5) years.
5. Charges for 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 coverage.
6. Charges for 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.
7. 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; or charges incurred in connection with the covered person having committed an assault and battery or a felony.
8. Charges for instructions for plaque control, oral hygiene or diet.

9. Charges for sealants, including any material other than fluorides, painted on the grooves of the teeth in an attempt to prevent further decay; except as may otherwise be covered as stated in the Explanation of Dental Benefits.
10. Charges for services rendered for treatment of Temporomandibular Joint Dysfunction (TMJ), including surgery, provided, however, that x-rays to diagnosis TMJ are covered.
11. Charges for the difference between the usual, customary and reasonable charges and the actual charges of the dentist or physician.
12. 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.
13. Charges for surgical trays when used in a surgical procedure.
14. Charges for claims that ACS Benefit Services, LLC cannot process without additional information from the claimant or provider.
15. Charges for 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 or 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.
16. Charges related to a hospital or out-patient facility.
17. Charges for prescription drugs and/or medications.
18. Charges for an anesthesiologist filed separately from the oral surgeon's charges.
19. Charges for treatment or services for which benefits are payable under the covered person's medical plan or another dental plan.

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

This 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.

ELIGIBILITY FOR THIS PLAN

Employee

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 1,560 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 1,560 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 Child(ren) through age 25 (that is, through the end of the month of such Child's 26th birthday). The Participant must notify the Plan Administrator within thirty (30) days of the date when a Child loses eligibility under this paragraph. For definition of Children see **Who, Other Than the Participant (Employee), may be Covered?**;
- Physically and/or Mentally Disabled 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 or mentally disabled Child over age 25 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.

Your "child(ren)" include:

- Your own natural or adopted children, or children placed for adoption with you;
- Stepchildren; and
- A child for whom you have been appointed legal guardian or a foster child.

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

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 benefits eligible 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.

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 benefits eligible service, actively-at-work.

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.

Annual Enrollment

This Dental Program allows enrollment annually each 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. Dental participants may change from High Option to Low Option or from Low Option to High Option during this Annual Enrollment period. Enrollment elections cannot be modified outside of the annual enrollment period unless the Employee experiences a Section 125 event recognized by the WFU Section 125 Plan. Enrollment changes must be requested within 30 days of the event and must be consistent with the event.

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* 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* 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 parents are employees of the Plan Sponsor, children of such employees may be covered under the Plan as children of either parent but not both. Employees who are spouses of employees may be covered either as spouses of the employee or as employees, but not both.

Exhaustion of COBRA Coverage For Special Enrollment Purposes

This Plan 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 For Special Enrollment Purposes

This Plan 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

The Leave of Absence Period is 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.

Coverage Termination

Your coverage terminates on the earlier date to occur of: when the Employer terminates the Plan; when 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.

Termination of Coverage Date

Termination of Coverage Date means:

- the last day of the month coinciding with or following the day eligibility is lost due to termination of employment; or
- the date eligibility is lost for all other reasons

Refer to "When Does Coverage Terminate?" for additional information.

TERMS AND PHRASES

Employer (and Plan Sponsor)

Employer Name:	Wake Forest University	
Address:	Human Resources Office, Campus #7424	P O Box 7424
City, State, & Zip	Winston-Salem, NC 27106	Winston-Salem, NC 27109
EIN:	56-0532138	
Telephone #:	336-758-4700	
Fax #:	336-758-6127	

Participating Employers

Wake Forest University
The Reynolda House Museum of American Art

Plan Name

Wake Forest University Health and Welfare Benefit Plan

Plan Number

Plan Number for Administration Purposes is 003.

ERISA Plan Number

501

Type of Plan

Welfare plan providing dental coverage.

Plan Trustees

None. Plan is not funded with a trust.

Benefit Year

The Benefit Year is Calendar Year.

Plan Year

Plan Year means the twelve (12) month period from July 1st through June 30th.

Plan Supervisor

Plan Supervisor means ACS Benefit Services, LLC, 8025 North Point Boulevard, Winston-Salem, NC 27106, telephone: 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

Plan Coordinator 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

This Plan coordinates benefits with other plans by the 100% method. 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

Participant Contributions are required?

	WFU Participant <u>Coverage</u>	Reynolda House Participant <u>Coverage</u>	WFU and Reynolda House Dependent <u>Coverage</u>
<u>Benefit</u>			
Dental	Yes	Yes	Yes

The Amounts of the Participant contributions are calculated by the Employer. No health insurance issuer is responsible for the financing or administration of this Plan.

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 *FAIR Health*. As guides for procedural coding, this Plan uses the American Dental Association's Current Dental Terminology (CDT) Manual and other nationally recognized coding guidelines.

SPECIAL ALERTS TO COVERED PERSONS

Claims must be submitted to the Plan Supervisor within the claim filing period in the **TERMS AND PHRASES** section. 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 piling 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 misrepresentation 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.

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

The Plan's benefits, including the determination of reasonable and customary charges, are paid using the Benefit Processing Guide shown in the **TERMS AND PHRASES** section.

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 health care coverage for yourself, your spouse or children 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 and the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

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 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 suit in a State or Federal Court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The Court will decide who should pay Court costs and legal fees. If you are successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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. 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.

If a Covered Person or other beneficiary, including a Provider, has been paid benefits under this Plan that are in excess of the benefits that should have been paid, or which should not (under the provisions of the Plan) have been paid, the Plan Administrator may cause the deduction of the amount of such excess or improper payment from any subsequent benefits payable to such Covered Person, beneficiary or Provider or other present or future amounts payable to such person, or recover such amount by any other legal method that the Plan Administrator, in its sole discretion, shall determine. Each Covered Person hereby authorizes the deduction of such excess payment for such benefits or other present or future compensation payments. 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.

CLAIMS

Filing a Claim

Dental claims will usually be submitted directly to the Plan Supervisor by your dental Provider to the address on your I.D. card. In some instances, you may need to file a claim with the Plan Supervisor. When this becomes necessary, make sure that you include the Subscriber's name and Subscriber ID number. The address to send claims to is P.O. Box 2000, Winston-Salem, NC 27102. Send the claim to the Plan Supervisor within the Claim Filing Period as stated under Terms and Phrases. Failure to do so may result in the Plan Supervisor denying your claim. Claims will be processed and responded to within the time limits prescribed by the Department of Labor. The amount of time within which claims must be responded to depends on the type of claim involved. See Claims and Appeals.

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 Terms and Phrases section.
- 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 layperson 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 than 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 Adverse Benefit Determination Upon Review (Appeal)

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; accident details/third party liability information; an itemized bill; complete orthodontic plan; dates of procedures and other significant dates; 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.acsbenefitservices.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 IN GENERAL

When are You, Your Spouse and Children Eligible?

Initial Eligibility

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 the following time period to be covered:

- Contributory health (where you are required to pay for coverage) - within thirty (30) days of becoming eligible.

Enrolling After Initial Eligibility

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 Open Enrollment or; (c) this Plan permits Late Enrollment. If you fail to apply for coverage on a timely basis, you will be a Late Enrollee. Your Spouse and Children become eligible for coverage when you do. If any Spouse or Child is not enrolled when first eligible, the same rules about applying for coverage at a later date apply. If your Spouse or Children 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 Spouse and Children will be the first day of the month following written application or the day coverage becomes effective for the Employee, whichever is later.

Re-enrolling After Loss of Coverage

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.

Re-enrolling When Re-hired

If this Plan has a re-employment 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.

Newly Acquired Spouse and Children

Coverage for newly acquired Spouse and Children is not automatic. Newly acquired Spouse and Children must be timely enrolled under the Special Enrollment Rules for coverage to be effective as a Special Enrollee. To timely enroll new Spouses and Children, you must apply within thirty (30) days of the date of eligibility (date of marriage (for a new Spouse or Step-Child), date of birth, date of adoption, or date child is placed for adoption or date of custody of a foster child). Such thirty (30) day period is extended to one hundred eighty (180) days for a Child or Spouse in cases in which the addition of such Spouse or Child 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 Spouse or Child is applied for more than thirty (30) days (or more than one hundred eighty [180] days where the Employee's contribution does not change) following the date of such Spouse or Child's eligibility for coverage, the Spouse or Child will be a *Late Enrollee*.

Being covered and being fully protected are not necessarily the same. You may be a Participant in the Plan with limited coverage as explained in the pre-existing conditions section.

Coverage for Qualified Medical Child Support Order Alternate Recipients

Your Plan will provide coverage for any of your 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.

Coverage for Adopted and Foster Children

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 the 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.

Coverage When Employees Transfer From Countries Outside the United States

Employees of the Plan Sponsor who transfer to a facility or location in the United States from a facility or location outside the United States shall become eligible for coverage as if they were newly hired at the time of the transfer. The Enrollment date for such transferred employees shall be the day they are first assigned to begin work at the location or facility to which they were transferred. Spouse and Children of such transferred Employees shall also be eligible for coverage. If a covered Employee does not initially enroll his or her Spouse or Children in this Plan because the Spouse or Children reside outside the United States at the time of the Covered Employee's enrollment, the Covered Employee shall be allowed to enroll the Spouses or Children upon the Spouse or Children's relocation to the United States, provided they are enrolled within thirty (30) days of the joining the Covered Employee. The effective date of the Spouse or Children's coverage shall be the date of their relocation.

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.

Spouses and Children as Employees

A Covered Spouse or Child 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 Spouse or Child prior to his or her Enrollment Date. Likewise, an otherwise eligible 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 Spouse or Children because of other health coverage, you may in the future be able to enroll yourself and your Spouse or Children in this Plan, provided you request enrollment (coverage) within thirty (30) days (sixty (60) days if the lost coverage was with Medicaid or the State Children's Health Insurance Program) 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 Spouse or Child was covered under a group health plan or had health 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 Spouse or Child 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, Spouse or Child) 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 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 (sixty (60) days for loss of Medicaid or coverage under the State Children's Health Insurance Program) after the date of: (a) exhaustion of COBRA coverage; (b) termination of coverage due to *loss of eligibility* for the coverage; or (c) termination of employer contributions towards such coverage. If coverage for an individual is applied for more than thirty (30) days (sixty (60) days for loss of Medicaid or coverage under the State Children's Health Insurance Program) 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 Spouse and Child drops coverage under this Plan in order to take coverage under another comparable group plan. All other Special Enrollment rules shall apply.

Otherwise eligible Spouses and 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 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 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 Children may enroll in the Plan.
2. When an otherwise eligible Spouse or Child(ren) loses other coverage and all the Special Enrollment rules above apply, the Employee may enroll but only the Spouse or Child who lost coverage may enroll.

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 Spouses and Children

If you have a new Spouse or Child as a result of marriage, birth, adoption, placement for adoption, obtaining custody of a foster child or acquiring a step-child(ren) by marriage, you may enroll yourself, if not already covered, your Spouse and your new Child(ren), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, placement for adoption or obtaining custody of the foster child. Other Children that you already have are not eligible to be enrolled under this provision. When a new Spouse and Children 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 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, the effective date of coverage for your Spouse and your foster child shall be the first day of the month following the date that sufficient evidence has been received to determine that the Child is eligible, but no earlier than the date the Participant obtained custody of the child. 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 Spouse and Child 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 eligible 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 is acquired after the Employee's initial eligibility date shall be the date of the marriage to the parent of the step-child.

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.

Who, Other Than the Participant (Employee) May be Covered?

In general, your Spouse and your Children may be covered if properly enrolled.

- A Spouse is someone from whom you are not legally divorced.
- A Child is: A Participant's child who meets all of the following conditions:
 1. Is a resident of the same country in which the Participant resides;
 2. Is a natural child; a stepchild; a legally adopted child [final adoption before attaining age eighteen (18) and a child who is *placed for adoption* before attaining age eighteen (18)]; or a foster child. The term *placed for adoption* means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such

person terminates upon the termination of such legal obligation. A foster child is an individual who has been placed with the Participant by an authorized agency or by judgment, decree or other order of any court with competent jurisdiction; and

3. Is younger than the Maximum Eligibility Age for Children of the Participant as shown in the Eligibility for this Plan section.

Covered Children under age 26 who are not eligible for coverage under this definition who were eligible under the definition of Child in the Plan at time of their enrollment shall remain eligible until they voluntarily drop coverage or lose coverage under the provisions of Maximum Eligibility Age of Children of the Participant in the Eligibility for this Plan section.

Regardless of age, a physically or mentally disabled Child may be covered if satisfactory proof of condition is provided and approved by the Plan Supervisor and if so indicated in the Eligibility for This Plan section.

When Does Coverage Terminate?

Your coverage terminates when the Employer terminates the Plan; when 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 actively-at-work requirements (except for extension of benefits coverage); when you fail to make a required contribution to the Plan or when you voluntarily terminate coverage. You will be allowed to re-enroll in the Plan if your Plan allows Late Enrollment or has an Open Enrollment Period.

The Plan may provide for extended coverage while you are on an Employer-approved leave of absence or while you are disabled. Leave of absence and disability extension provisions, if any, are set out under 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.

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, 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 children) different rights or protections, the law that provides the greater benefit will apply. COBRA and USERRA coverage run concurrently.

Definitions For USERRA

“*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. For example, George takes a leave of absence for service in the Uniformed Services beginning on August 1, 2012. 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/Disenrollment 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 disenrolled 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 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".

COORDINATION OF BENEFITS

Coordination of Benefits

In the situation where a person covered under this Plan is also covered under another plan (see “other plans,” below), this Plan and the other plan will decide who pays first (the primary plan) and who pays second or third (the secondary plan). In situations where this Plan is the secondary coverage for your claim, this Plan will determine how much, if any, of the balance to pay depending on which of two (2) methods this Plan uses: “100% Coordination of Benefits (COB)” or “Non-Duplication of Benefits.” The Schedule of Dental Benefits indicates which method this Plan uses. 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. Under Non-Duplication of Benefits, the Plan pays the difference between what the primary plan paid and what this Plan would have paid if it had been primary. Sometimes this calculation will result in no additional amount paid.

If the manner in which an expense is incurred is such that none of the plan providing coverage would consider such expense a Usual, Reasonable and Customary charge, such expense shall not be considered an allowable expense.

If the expense is covered under at least one of the plans providing coverage and if only part or none of the expense is payable as a benefit only because of a Deductible, coinsurance or other such limitations, the entire amount shall be considered an allowable expense.

Other Plans

As used in this section, the term “other plans” shall be deemed to include any of the following:

1. Insurance or any arrangement of benefits for individuals or a group. Examples include: employer plans, Blue Cross Plans, HMO plans.
2. Prepayment coverage or any other coverage toward the cost of which any employer makes contributions or payroll deductions or any labor union makes contributions.
3. A labor-management trustee plan, union welfare plan, employer organization plan or employee organization plan.
4. Any governmental program or coverage required to be provided by statute unless such plan specifically excludes coordination.
5. Coverage for students sponsored by, or provided through a school or other educational institution.
6. Coverage for expenses due to accidental bodily injury or disease to the extent to which payment as a judgment, settlement or otherwise is made by any person or persons considered responsible for such injury or disease or by their insurers.
7. Coverage provided to any person due to resident or citizen status of a foreign country or other foreign governmental entity.

Order of Benefit Determination

In coordinating benefits, one of the two (2) or more plans involved shall be designated the primary plan and the others shall be designated secondary plans as provided in the following paragraph. The primary plan shall pay without regard to the other plans. The secondary plans shall coordinate their payments so that the total of the payments from all plans shall not exceed the allowable expenses. Notwithstanding the above, no plan shall pay more than it would have paid in the absence of this Coordination of Benefits Provision.

The Order of Benefit Determination is as follows:

1. The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent.
2. For children’s expenses, the primary plan is the plan of the parent whose birthday (omitting year of birth) is earlier in the Calendar Year. If both parents have the same birthday, the Plan that has covered either of the parents longer is primary.
3. For children’s expenses when the parents are separated or divorced, if there is a court decree that establishes which parent is responsible for the financing of medical, dental or other health care expenses with respect to children, the benefits are determined in agreement with the court decree. Otherwise, if the parent with custody has not remarried, the primary plan is the plan of the parent with custody. If the parent with custody has remarried, the primary plan is the plan of the parent with custody, secondary is the stepparent’s plan, and the third plan is the plan of the parent without custody.

4. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the Plan covering the person as an Employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.
5. If any plan lacks a coordination of benefits provision, or has coordination provisions different from this Plan, then that plan is the primary plan.
6. The plan or coverage provided to any person due to such person's residency or citizenship status by a foreign country or other foreign governmental entity shall be primary and this Plan shall be secondary.
7. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

This Plan will be primary to coverage under a Medicaid or State Children's Health Insurance Program under Titles XIX and XXI of the Social Security Act through which an Employee receives premium assistance or supplemental coverage.

TriCare is the primary plan for active duty service members, including activated National Guard and Reserve members. This Plan is primary for dependents of TriCare service members and service member retirees.

The Plan may give or obtain needed information from another plan in order to properly pay claims in accordance with this section. This information may be given or obtained without the consent of, or notice to, the Covered Person. Covered Persons may be requested to give this Plan information the Plan needs about another plan and the payment by such plan of allowable charges. Failure to provide this information may result in denial of the Covered Person's claim.

Whenever benefits may have been paid with respect to allowable expenses in a total amount, at any time, in excess of the minimum amount of payment necessary at that time to satisfy the intent of the coordination of benefits provision stated above, the Plan Administrator shall have the right to recover such payments to the extent of such excess from among any one or more of the following, as the Plan Administrator shall determine: any person to, for or with respect to whom such payments were made, any insurance companies or any other organizations.

The Plan Administrator shall have the right to cause the payment to any organizations making payments under other plans which should have been made under the Plan of any amounts it shall determine to be warranted to satisfy the intent of the coordination of benefits provision stated above.

PRIVACY PRACTICES

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You May Obtain Access To This Information. This Notice is effective September 15, 2013. Please Review This Notice Carefully.

If you have any questions about this notice, please contact the Privacy Official at 336-758-4700.

Who Will Follow This Notice

During the course of providing you with health coverage, the Plan will have access to information about you that is deemed to be “protected health information,” or PHI, by the Health Insurance Portability and Accountability Act of 1996, or HIPAA. The procedures outlined in this section have been added to the Plan to ensure that your PHI is treated with the level of protection required by HIPAA. This notice describes the medical information practices of this Plan and that of any third party that assists in the administration of Plan claims.

The Plan’s Pledge Regarding Medical Information

This health Plan understands that medical information about you and your health is personal. The Plan is committed to protecting medical information about you. The Plan creates a record of the health care claims reimbursed under the Plan for Plan administration purposes. This notice applies to all of the medical records that are maintained. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office or clinic.

This notice will tell you about the ways in which the Plan may use and disclose medical information about you. It also describes the Plan’s obligations and your rights regarding the use and disclosure of medical information.

The Plan is required by law to:

- Give you this notice of the Plan’s legal duties and privacy practices with respect to medical information about you; and
- Notify you in the event of a breach of your secured PHI; and
- Follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Medical Information about You

The following categories describe different ways that the Plan uses and discloses medical information. An explanation and some examples are provided for each category of uses or disclosures. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

For Payment

(as described in applicable regulations)

The Plan may use medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health Plan to coordinate benefit payments.

For Health Care Operations

(as described in applicable regulations)

The Plan may use and disclose medical information about you for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services and fraud and abuse detection programs; business planning and development such as cost management and business management and general Plan administrative activities.

As Required by Law

The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety

The Plan may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose medical information about you in a proceeding regarding the licensure of a Physician.

Business Associates

The Plan contracts with individuals and entities (Business Associates) to perform various functions on the Plan's behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose protected health information but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. An example of a Business Associate would be the Plan's Third Party Administrator, ACS Benefit Services, LLC, which will be handling many of the functions in connection with the operation of the Group Health Plan.

Special Situations

Disclosure to Health Plan Sponsor

Medical information may be disclosed to your employer, the Plan Sponsor, solely for purposes of administering benefits under the Plan. This would include providing information to the Plan Sponsor when the Plan Sponsor is helping you understand your claims or when the Plan Sponsor helps you to make a claim payable.

Military and Veterans

If you are a member of the armed forces, the Plan may release medical information about you as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

The Plan may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities

The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the person's agreement;
- about a death the Plan believes may be the result of criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about Members to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others or (3) for the safety and security of the correctional institution.

Emergency Situations

We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interests, we will disclose only the PHI that is directly relevant to the person's involvement in your care.

Group Health Plan Disclosures

We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.

Underwriting Purposes

We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. You may not, however, inspect or copy psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Official. A form for the request is available from the Privacy Official at the telephone number on the first page of this Notice. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend

If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Official. A form for the request is available from the Privacy Official. In addition you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures

You have the right to request an “accounting of disclosures” where such disclosure was made for any purpose other than treatment, payment or health care operations. To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Official at the telephone number on the first page of this Notice. Your request must state a time period which may not be longer than six (6) years and may not include dates before April 2004. A form for the request is available from the Privacy Official. Your request should indicate in what form you want the list (for example, on paper, electronic). The first list you request within a twelve (12) month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. You will be notified of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. The Plan is not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Official at the telephone number on the first page of this Notice. In your request, you must say (1) what information you want to limit; (2) whether you want to limit the use, disclosure or both and (3) to whom you want the limits to apply, for example, disclosure to your Spouse. A form for the request is available from the Privacy Official.

Right to Request Confidential Communications

You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location if you would be endangered if the Plan continued to send your medical correspondence to the subscriber. For example, you can ask that the Plan send your explanation of benefits to an alternate address.

To request confidential communications, you must make your request in writing to the Privacy Official whose telephone number is on the first page of this Notice. No one will ask you the reason for your request.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, please contact the Privacy Official at the telephone number on the first page of this Notice.

Changes to This Notice

The Plan reserves the right to change this Notice. The Plan reserves the right to make the revised or changed notice effective for medical information the Plan already has about you as well as any information received in the future. The Plan will post a copy of the current notice on the Plan website if and when the Plan creates a website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Official at the telephone number on the first page of this Notice. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you give permission to the Plan to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain records of the claims submitted on your behalf.

CONTINUATION COVERAGE UNDER COBRA

Introduction

The following information about your right to continue your health care coverage in the Plan is important. **Please read it very carefully.** This section on COBRA applies only to the dental portion of your health coverage. Wherever the word “Plan” is used, it refers to your dental coverage.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

COBRA applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by the Plan Sponsor (such as life insurance, disability or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand your rights beyond COBRA’s requirements. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

Plan Administrator

Wake Forest University
Human Resources
2598 Reynolda Rd., Campus #7424
Winston-Salem, NC 27106
Telephone: 336-758-4700
Fax: 336-758-6127

COBRA Administrator

Stanley, Hunt, Dupree and Rhine
Telephone: 336-992-0028

What is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who Is Entitled to Elect COBRA?”

After a qualifying event occurs and any required notice of that event is properly provided to the COBRA Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary”. You, your Spouse and your Children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun “you” in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who is Entitled to Elect COBRA?

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

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

If you are the Spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are a Child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a "Child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's Spouse and Children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or become covered during the FMLA leave) and (2) they will lose Plan coverage within eighteen (18) months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same eighteen (18) month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special election period lasts for sixty (60) days or less. It is the sixty (60) day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six (6) months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. **CONTACT THE PLAN ADMINISTRATOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE THE RIGHT TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD.**

When is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the COBRA Administrator of any of these three (3) qualifying events.

For the other qualifying events (divorce or legal separation of the employee and Spouse or a Child's losing eligibility for coverage as a Child), a COBRA election will be available to you only if you notify the COBRA Administrator in writing within sixty (60) days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the COBRA Administrator. Under federal law, you must have sixty (60) days after the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan.

Mail, fax or hand deliver the completed Election Form to the address or fax number on the Election Form.

The Election Form must be completed in writing and mailed, faxed or hand delivered to the individual and address on the Election Form. The following are not acceptable as COBRA elections and will not preserve

COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail communications.

If mailed, your election must be postmarked (and if hand delivered or faxed, your election must be received by the individual at the address or fax number on the Election Form) no later than sixty (60) days after the date of the COBRA election notice provided to you at the time of your qualifying event. IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's Spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several or for all Children who are qualified beneficiaries. Covered employees and Spouses (if the Spouse is a qualified beneficiary) may elect COBRA on behalf of all qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the sixty (60) day election period specified on the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When you complete the Election Form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and if so, the date of the Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address or fax number on the Election Form.

Qualified beneficiaries may be enrolled only in the group health components of the Plan in which they were enrolled at the time of the qualifying event.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage before the End of the Maximum Coverage Period".

Special Consideration in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage before the End of the Maximum Coverage Period".

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation or a Child's losing eligibility as a Child, COBRA coverage can last for up to a total of thirty-six (36) months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee becomes entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage under the Plan's Dental components for his Spouse and Children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours. Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of eighteen (18) months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce or legal separation or a Child's loss of eligibility.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the sixty-first day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's determination of disability within sixty (60) days after the latest of:

- the date the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If notice is not provided in writing during the sixty (60) day notice period and within eighteen (18) months after the covered Employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

An extension of coverage will be available to Spouses and Children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a Child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within sixty (60) days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If notice is not provided during the sixty (60) day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition of the qualified beneficiary has been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period”.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator in writing within thirty (30) days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within thirty (30) days after the Social Security Administration’s determination.

If the Social Security Administration’s determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than thirty (30) days after the Social Security Administration’s determination that the qualified beneficiary is no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period”.)

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed one hundred two percent (102%) (or, in the case of an extension of COBRA coverage due to a disability, one hundred fifty percent (150%)) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the tax provisions, eligible individuals can take a tax credit equal to sixty-five percent (65%) of premiums paid for qualified health coverage, including COBRA coverage. The American Recovery and Reinvestment Act of 2009 made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact

Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

Payment for COBRA Coverage

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the COBRA Administrator. Your COBRA Election Form will specify the appropriate mailing address and telephone number for inquiries.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if the check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than forty-five (45) days after the date of your election. (This is the date your election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand delivered or faxed.) See the section above entitled "Electing COBRA Coverage".

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the forty-fifth (45) day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided below to confirm the correct amount of your first payment.

Provider claims and claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within forty-five (45) days after the date of your election, you will lose all COBRA rights under the Plan.

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The COBRA Administrator will not send periodic notices of payments due for these coverage periods (that is, they will not send a bill to you for your COBRA coverage -- it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of thirty (30) days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly premium later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim that you or a provider submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

More Information About Individuals Who May be Qualified Beneficiaries

A child born to, adopted by or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment with the Plan Sponsor is entitled to the same rights to elect COBRA as an eligible Child of the covered employee.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or the COBRA Administrator.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from the Plan Administrator at the address and phone number in the Schedule of Benefits or from the COBRA Administrator:

Stanley, Hunt, Dupree and Rhine
Telephone: 336-992-0028

The contact information for the plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from the Plan Administrator).

