CATHOLIC DIOCESE OF JACKSON

EMPLOYEE BENEFIT DENTAL PLAN
PRIEST PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

EFFECTIVE: October 1, 2013
Revised: January 1, 2016

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

NOTICE

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 601-969-1880.

TABLE OF CONTENTS

ADOPTION OF THE PLAN DOCUMENT 1
ADMINISTRATIVE INFORMATION 2
SCHEDULE OF DENTAL BENEFITS 3
DENTAL CARE COVERAGES 4
DENTAL LIMITATIONS AND EXCLUSIONS 11
GENERAL EXCLUSIONS 15
COORDINATION OF BENEFITS 17
SUBROGATION AND REIMBURSMENT 20
ELIGIBLITY AND EFFECTIVE DATES 22
TERMINATION OF COVERAGE 26
EXTENSION OF COVERAGE 28
CONTINUATION OF COVERAGE OPTION 30
CLAIMS PROCEDURES FOR DENTAL COVERAGE 32
GENERAL PLAN INFORMATION 43
HIPAA PRIVACY RULE AND SECURITY STANDARDS 47

ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document and Summary Plan Description (the "Plan Document") as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document is a restatement of any prior plan document, with benefit changes, and is effective on January 1, 2016.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for Eligible Employees of the Employer and their Eligible Dependents. The benefits provided by the Plan include:

COVERAGES
Dental

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed, effective as of January 1, 2016.

CATHOLIC DIOCESE OF JACKSON

By: ____

Title: ____

Date: ____

ADMINISTRATIVE INFORMATION

Name of Plan:	Catholic Diocese of Jackson Employee Health Protection Plan
Plan Sponsor: Address:	Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201
Business Phone Number:	601-969-1880
Plan Sponsor ID Number (EIN):	64-0303073
Plan Number:	501
Plan Year:	January 1
Plan Benefits:	Dental
Plan Administrator (Named Fiduciary): Address:	Aad de Lange Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201
Business Phone Number:	601-969-1880
Designated Legal Agent: Address:	Catholic Diocese of Jackson 237 East Amite Street Jackson, Mississippi 39201

(Legal process may also be served upon the Plan Administrator.)

Participating Employers:	Catholic Diocese of Jackson
Contract Administrator:	Boon-Chapman Benefit Administrators, Inc.
Street Address:	9401 Amberglen Blvd. Building 1, Suite 100 Austin, Texas 78729
Mailing Address:	P.O. Box 9201 Austin, Texas 78766
Phone:	(512) 454-2681 / (800) 252-9653
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SCHEDULE OF DENTAL BENEFITS

Benefit Maximums

The maximum payable for eligible dental expenses for each covered person shall not exceed the maximums shown below.

Calendar Year Maximum per Covered Person for Preventive, Basic, and Major Services	$1,500

Deductibles

A deductible is an amount that a covered person must contribute toward payment of eligible dental expenses.

Deductible, per Person, per Calendar Year	$0
Maximum Deductible per Family, per Calendar Year	$0

Co-insurance

Co-insurance is the percentage of eligible expenses that the plan pays after any deductible requirement has been satisfied. The co-insurance percentages are as follows:

Preventive Services	100%
Basic Services*	100%
Major Services*	100%

Waiting Periods

A waiting period is the length of time a member must be enrolled in the dental plan before specific services are available.

Preventive Services	No waiting period.
Basic Services	No waiting period.
Major Services	12 month waiting period.

DENTAL CARE COVERAGES

Covered Expenses

Except as otherwise noted below or in the dental Schedule of Benefits, Covered Expenses are the Maximum Eligible Charges for services listed below that are Incurred by a Covered Person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of this Plan Document. The Plan provides benefits only for the most cost-effective treatment of a dental condition, which provides a professionally acceptable result as determined by national standards of dental practice. Services or supplies that do not meet accepted standards of dental practice, or are not furnished by a Dentist, except for x-rays or services rendered by a Dental Hygienist under the supervision of a Dentist, will not be covered.

Type I - Preventive Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the plan.

Bitewing x-rays - Only 2 sets in any Calendar Year. Limited to a maximum of 4 films per set.

Clinical oral evaluation - Only 2 per Calendar Year.

Complete Mouth Survey – Only 1 in any consecutive 36-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.

Panoramic x-rays - Only 1 in any consecutive 36-month period. For benefit determination purposes a full mouth series will be determined to include bitewings and 10 or more periapical x-rays.

Individual Periapical x-rays - A maximum of 4 periapical x-rays which are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.

Intraoral Occlusal x-rays - Limited to 2 films in any consecutive 12-month period.

Prophylaxis (Cleaning) - Only 2 prophylaxis or periodontal maintenance procedures per Calendar Year.

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 14 years old. Only 1 per person per consecutive 12-month period.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only 1 treatment per tooth in any consecutive 36-month period.

Space Maintainers - Limited to non-orthodontic treatment for prematurely removed or missing teeth for a person less than 14 years old.

Palliative (emergency) Treatment of Dental Pain – Minor Procedures - paid as a separate benefit only if no other service, except x-rays, is rendered during the visit.

Periodontal Maintenance Procedures Following Active Therapy - Payable only if at least 6 consecutive months have passed since the completion of active periodontal surgery. Only 2 periodontal maintenance procedures or adult prophylaxis are payable in any Calendar Year.

Type II - Basic Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the plan.

Denture Adjustments - Only covered 1 time in any consecutive 12-month period, and only if performed more than 6 consecutive months after the insertion of the denture.
Relining Dentures, Rebasing Dentures - Limited to relining or rebasing done more than 6 consecutive months after the initial insertion, and then not more than 1 time in any consecutive 36-month period.

Tissue Conditioning - maxillary or mandibular - Payable only if at least 12 consecutive months have elapsed since the insertion of a full or partial denture and only once in any consecutive 36-month period.

Repairs to Crowns and Inlays

Recement Inlays - No limitation.

Recement Crowns - No limitation.

Repairs to Crowns - Limited to repairs performed more than 12 consecutive months after initial insertion.

Repairs to Dentures and Bridges

Repairs to Full and Partial Dentures - Limited to repairs performed more than 12 consecutive months after initial insertion.

Recement Fixed Partial Denture - Limited to repairs performed more than 12 consecutive months after initial insertion.

Fixed Partial Denture Repair, by Report - Limited to repairs performed more than 12 consecutive months after initial insertion.

Fillings

Amalgam Restorations - Benefits for replacement of an existing amalgam restoration are only payable if at least 12 consecutive months have passed since the existing amalgam was placed.

Composite Resin Restorations - Benefits for the replacement of an existing composite restoration are payable only if at least 12 consecutive months have passed since the existing filling was placed.

Benefits for composite resin restorations on bicuspid and molar teeth will be based on the benefit for the corresponding amalgam restoration.

Pin Retention - Covered only in conjunction with amalgam or composite restoration. Payable one time per restoration regardless of the number of pins used.

Routine Extractions

Routine Extraction - Includes an allowance for local anesthesia and routine postoperative care.

Root Removal - Exposed Roots - Includes an allowance for local anesthesia and routine postoperative care.

Minor Periodontal Procedures

Periodontal Scaling and Root Planing (if not related to periodontal surgery) - Per Quadrant - Limited to 1 time per quadrant of the mouth in any consecutive 36-month period. Not separately payable if performed on the same treatment plan as prophylaxis.

Type III - Major Services

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services according to all provisions, requirements and limitations of the plan.

Inlays, Onlays and Crowns

Inlays and Onlays - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 5 years have elapsed since the last placement.

Crowns - Covered only when the tooth cannot be restored by an amalgam or composite filling due to major decay or fracture, and then only if more than 5 years have elapsed since the last placement. For persons under 16 years of age, benefits for crowns on vital teeth are limited to Resin or Stainless Steel Crowns. Benefits for crowns are based on the amount payable for nonprecious metal substrate.

Stainless Steel Crowns, Resin Crowns - Covered only when the tooth cannot be restored by filling and then only 1 time in a consecutive 36-month period. Limited to persons under the age of 16.

Post and Core (in conjunction with a crown or inlay) - Covered only for endodontically treated teeth with total loss of tooth structure.

Endodontic Procedures

Therapeutic Pulpotomy - Payable for deciduous teeth only.

Root Canal Therapy, Primary Tooth (excluding final restoration) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy - Permanent Tooth includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Root Canal Therapy, Retreatment - by Report - Covered only if more than 24 consecutive months have passed since the original endodontic therapy and only if necessity is confirmed by professional review.

Apexification - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. A maximum of 3 visits per tooth are payable.

Apicoectomy - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Retrograde Filling (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care. Not separately payable on the same date and tooth as an Apicoectomy.

Root Amputation (per root) - Includes all preoperative, operative and postoperative x-rays, bacteriological cultures, diagnostic tests, local anesthesia and routine follow-up care.

Hemisection - Fixed bridgework replacing the extracted portion of a hemisected tooth is not covered. Procedure includes local anesthesia and routine postoperative care.

Major Periodontal Surgery

Gingivectomy - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Gingival Flap Procedure Including Root Planing - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Clinical Crown Lengthening - Hard Tissue - No limitation.

Osseous Surgery - only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period.

Bone Replacement Graft — First Site Quadrant.

Bone Replacement Graft — Each Additional Site in Quadrant.

Guided Tissue Regeneration - Resorbable Barrier - per Site, per Tooth - Only 1 periodontal surgical procedure is covered per area of the mouth in any consecutive 36-month period. Not payable as a discrete procedure if performed during the same operative session in the same site as osseous surgery.

Pedicle Soft Tissue Graft - No limitation.

Free Soft Tissue Graft (including donor site surgery) – No limitation.

Subepithelial Connective Tissue Graft Procedure (including donor site surgery) - No limitation.

Distal or Proximal Wedge Procedure (when not performed in conjunction with surgical procedures in the same anatomical area) - No limitation.

Oral Surgery

Surgical Extractions

Surgical Extractions (except for the removal of impacted teeth) - Includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Residual Tooth Roots (Cutting Procedure) - Includes an allowance for local anesthesia and routine postoperative care.

Other Oral Surgery

Tooth Transplantation (includes reimplantation from one site to another and splinting and/or stabilization) - Includes an allowance for local anesthesia and routine postoperative care.

Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption - Includes an allowance for local anesthesia and routine postoperative care.

Biopsy of Oral Tissue - Includes an allowance for local anesthesia and routine postoperative care.

Alveoloplasty - Includes an allowance for local anesthesia and routine postoperative care.

Vestibuloplasty - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Removal of Odontogenic Cyst or Tumor - Includes an allowance for local anesthesia and routine postoperative care.

Removal of Exostosis - Maxilla or Mandible - Includes an allowance for local anesthesia and routine postoperative care.

Incision and Drainage - Includes an allowance for local anesthesia and routine postoperative care.

Osseous, Osteoperiosteal, or Cartilage Graft of the Mandible or Facial bones - Autogenous or Nonautogenous, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Frenectomy (Frenulectomy, Frenotomy), Separate Procedure - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Hyperplastic Tissue - Per Arch - Includes an allowance for local anesthesia and routine postoperative care.

Excision of Pericoronal Gingiva - Includes an allowance for local anesthesia and routine postoperative care.

Synthetic Graft - Mandible or Facial Bones, by Report - Includes an allowance for local anesthesia and routine postoperative care. Only payable when performed primarily to facilitate insertion of a removable denture.

Surgical Extraction of Impacted Teeth

Surgical Removal of Impacted Tooth - Soft Tissue – The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Partially Bony – The benefit includes an allowance for local anesthesia and routine postoperative care.

Surgical Removal of Impacted Tooth - Completely Bony – The benefit includes an allowance for local anesthesia and routine postoperative care.

Removal of Impacted Tooth - Completely Bony – with Unusual Surgical Complications - The benefit includes an allowance for local anesthesia and routine postoperative care.

Prosthetics

Full Dentures — There are no additional benefits for personalized dentures or overdentures or associated procedures. Limited to one time per arch per 5 years.

Partial Dentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Limited to one partial denture per arch per 5 years unless there is a Necessary extraction of an additional functioning Natural Tooth.

Add Tooth to existing partial denture — Only if more than 12 consecutive months after the insertion of the partial denture.

Complete and Partial Overdentures — There are no additional benefits for precision or semiprecision attachments. The benefit for a partial denture includes any clasps and rests and all teeth. Limited to one partial denture per arch per 5 years unless there is a necessary extraction of an additional Functioning Natural Tooth.

Post and Core (in Conjunction with a Fixed Bridge) — Covered only for endodontically treated teeth with total loss of tooth structure.

Prosthesis Over Implant — A prosthetic device, supported by an implant or implant abutment, is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 years old, is not serviceable and cannot be repaired.

Fixed Partial Dentures (Nonprecious Metal Pontics, Retainer Crowns, and Metallic Retainers)
Replacement: Benefits for the replacement of an existing bridge are payable only if the existing bridge is at least 5 years old, is not serviceable, and cannot be repaired. Benefits for retainer crowns and pontics are based on the amount payable for nonprecious metal substrates.

Cast Metal Retainer for Resin Bonded Fixed Bridge
Replacement: Benefits are based on the amount payable for nonprecious metal substrates. Benefits for the replacement of an existing resin bonded bridge are payable only if the existing resin bonded bridge is at least 5 years old, is not serviceable, and cannot be repaired.

Anesthesia and IV Sedation

General Anesthesia - Paid as a separate benefit only when Medically or Dentally Necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I.V. Sedation - Paid as a separate benefit only when Medically or Dentally Necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

Type IV - Orthodontic Services

The plan will provide benefits, as outlined on the Schedule of Dental Benefits, for expenses related to orthodontic services according to all provisions, requirements and limitation of the plan.

Each month of active treatment is a separate Dental Service.

Covered Orthodontic Treatment

cephalometric x-rays;

full mouth or panoramic x-rays taken in conjunction with an orthodontic treatment plan;

diagnostic casts (i.e., study models) for orthodontic evaluation;

surgical exposure of impacted or unerupted tooth for orthodontic purposes;

occlusal guards;

fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics during a Dependent child's lifetime will not be more than the Orthodontia Maximum shown in The Schedule. Benefits are payable under this plan only for active Orthodontic Treatment and for the Orthodontic services on the list of Dental Services for dependent children who are under age 19 on the date the Orthodontic Treatment is started. No benefits are payable for retention in the absence of full active Orthodontic Treatment. Charges will be considered, subject to other plan conditions, as follows:

25% of the total case fee will be considered as being incurred on the date the initial active appliance is placed; and

the remainder of the total case fee will be divided by the number of months for the total treatment plan and the resulting portion will be considered to be incurred on a monthly basis until the plan maximum is paid, treatment is completed or eligibility ends. Payments will be made quarterly.

Replacement Provisions for Orthodontic Coverage

Coverage will be provided if Orthodontic Treatment was started while your Dependent child was covered for Orthodontic benefits under the prior carrier's plan and:

Orthodontic Treatment is continued under this plan; and

proof that the Maximum Benefit under this plan was not equaled or exceeded by the benefits paid or payable under the previous plan is submitted to Plan;

In this case the Maximum Benefit for the Dependent child will be calculated determining:

the lesser of the Maximum Benefit of this plan and the maximum benefit of the replacement plan; and

subtracting the benefit paid or payable by the prior plan from the amount in the bullet above. The remainder of the benefit is payable under this plan.

In no event will the Dependent child receive more in Orthodontic benefits than the amount which the Dependent child would have received had the prior plan remained in effect.

DENTAL LIMITATIONS AND EXCLUSIONS

In addition to the General Health Care Coverage Exclusions, the Plan will not provide benefits for any of the items listed in this section. This list is intended to give you a general description of expenses for services and supplies not covered by this Plan. The Plan only covers those expenses specifically described as covered in the preceding section. There may be expenses in addition to those listed below which are not covered by the Plan.

Drugs
The administration or cost of drugs, unless otherwise specified.

Duplicate Services
Duplicate prosthetic devices, other duplicate appliances, or duplicate dental restoration.

Extension of Benefits
An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

> for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
>
> for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
>
> for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

Medical Services
Benefits otherwise provided under a medical plan.

Non-Covered Services
Services not specifically listed as Covered Expenses, which include but are not limited to the following:

> procedures which are not included in the list of Covered Dental Expenses;
>
> procedures which are not necessary and which do not have uniform professional endorsement;
>
> procedures for which a charge would not have been made in the absence of coverage or for which the covered person is not legally required to pay;
>
> any procedure, service, supply or appliance, the sole or primary purpose of which relates to the change or maintenance of vertical dimension;
>
> procedures, appliances or restorations whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of

the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;

the alteration or restoration of occlusion;

the restoration of teeth which have been damaged by erosion, attrition or abrasion;

bite registration or bite analysis;

any procedure, service, or supply provided primarily for cosmetic purposes. Facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth shall always be considered cosmetic;

the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;

crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture;

core build-ups;

replacement of a partial denture, full denture, or fixed bridge or the addition of teeth to a partial denture unless:

a) replacement occurs at least 5 years after the initial date of insertion of the current full or partial denture; or

b) the partial denture is less than 5 years old, and the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied); or

c) replacement occurs at least 5 years after the initial date of insertion of an existing fixed bridge if the prior bridge is less than 5 years.;

the removal of only a permanent third molar will not qualify an initial or replacement partial denture, full denture or fixed bridge for benefits;

the replacement of crowns, cast restoration, inlay, onlay or other laboratory prepared restorations within 5 years of the date of insertion;

the replacement of a bridge, crown, cast restoration, inlay, onlay or other laboratory prepared restoration regardless of age unless necessitated by major decay or fracture of the underlying Natural Tooth;

replacement of a partial denture or full denture which can be made serviceable or is replaceable;

replacement of lost or stolen appliances;

replacement of teeth beyond the normal complement of 32;

prescription drugs;

any procedure, service, supply or appliance used primarily for the purpose of splinting;

athletic mouth guards;

myofunctional therapy;

precision or semiprecision attachments;

denture duplication;

separate charges for acid etch;

labial veneers (laminate);

treatment of jaw fractures and orthognathic surgery;

charges for sterilization of equipment, disposal of medical waste or other requirements mandated by OSHA or other regulatory agencies and infection control;

charges for travel time; transportation costs; or professional advice given on the phone;

procedures performed by a Dentist who is a member of the covered person's family (the covered person's family is limited to spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents), except in the case of a dental emergency and no other Dentist is available;

temporary, transitional or interim dental services;

any procedure, service or supply not reasonably expected to correct the patient's dental condition for a period of at least 36 consecutive months as determined by Plan;

diagnostic casts, diagnostic models, or study models (non-orthodontic);

any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of ($100 - $200) per consecutive 12-month period);

oral hygiene and diet instruction; broken appointments;

completion of claim forms; personal supplies (e.g., water pick, toothbrush, floss holder, etc.); duplication of x-rays and exams required by a third party;

any charges, including ancillary charges, made by a hospital, ambulatory surgical center or similar facility;

services for which benefits are not payable according to the "General Exclusions" section.

Non-Standard Services
Services or supplies that do not meet accepted standards of dental practice, including charges for implantology and for services and supplies that are experimental in nature or not fully approved by a council of the American Dental Association.

Services not reasonably necessary or not customarily performed, or for charges exceeding the Maximum Eligible Charge for the service performed or materials furnished.

Orthodontics
Orthodontic services and/ or treatment, except as specified in the Covered Dental Expenses section.

Pre-existing Conditions
Unless otherwise required by applicable law, services for:

an appliance or modification of an appliance if the impression was made prior to becoming a Covered Person;

a crown, inlay, onlay bridge, or cast restoration if tooth preparation was made prior to becoming a Covered Person;

root canal therapy if the chamber was opened prior to becoming a Covered Person; or

any dental expense Incurred prior to the effective date of this Plan.

Replacement Prosthetics
Replacement of a lost, missing, or stolen prosthetic device or any other appliance.

Services Not Furnished by a Dentist
Services not furnished by a Dentist, except for x-rays ordered by a Dentist and services performed by a licensed Dental Hygienist under the supervision of a Dentist.

GENERAL EXCLUSIONS

The following exclusions apply to all benefits provided under this Plan, and no benefits shall be payable for:

Cosmetic Services
Any Surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except when:

necessary due to a non-occupational Accidental Injury;

necessary for correction of post-surgical deformity.

Court-Ordered Confinement
Any confinement of a Covered Person in a public or private institution as the result of a court order.

Criminal Activities
Any Injury or any complication thereof occurring during the Covered Person's commission of a felony offense or in the immediate flight therefrom.

Education or Training Program
Services performed by a Physician or other provider enrolled in an education or training program when such services are related to the program.

Excess Charges
Charges in excess of the Maximum Eligible Charges for services or supplies provided.

Forms Completion
Charges for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities
The Plan does not cover loss caused by or resulting from confinement or treatment for which the Covered Person is not legally obligated to pay, such as in any government hospital. However, the U.S. government has a right to recover or collect benefits for any care or services Incurred by a Covered Person as a result of a non-service-connected Injury or Illness. The U.S. government may recover or collect to the extent that the Covered Person would be eligible to receive benefits under this Plan if such care or services had not been furnished by a department or agency of the United States.

Immediate Family or Resident Care
Any service rendered to a Covered Person by a member of the Covered Person's Immediate Family or anyone who customarily lives in the Covered Person's household.

Incorrect and/or inappropriate coding and/or billing practices
Any portion of a claim that the administrator determines to be incorrectly or inappropriately billed by a physician, health professional, facility or hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period or take place on the same day, duplicate services, and inappropriate modifier use. The determination that a service was incorrectly or inappropriately billed is based on documentation from the Centers for Medicare and Medicaid Services, The National Correct coding Initiative and/or other coding vendors or industry regulatory agencies.

Investigative, Experimental, or Research Procedures
See definition of "Medically Necessary"

Late-Filed Claims
Claims that are not filed with the Contract Administrator for handling within 12 months after the date the expenses are Incurred.

Military Service
Charges for treatment of any Injury sustained or Illness contracted while in the military service of any country.

Missed Appointments
Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay
Services for which no charge is made or for which a Covered Person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this Plan.

Other Coverage
Health care services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

Outside United States
Charges Incurred outside of the United States if the Covered Person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

Prior Coverage
Services or supplies for which the Covered Person is eligible for benefits under the plan that this Plan replaces.

Prior to or After Coverage
Services are supplies that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Self-Inflicted Injury
Any expenses resulting from voluntary or involuntary self-inflicted Injury or voluntary or involuntary attempted self-destruction that occurred while the Covered Person was sane or insane, regardless of whether the Covered Person was aware of or in control of his actions. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Travel
Unless approved by the utilization management organization.

Veteran's Hospital
See "Government-Operated Facilities."

War
Medical or dental conditions resulting from insurrection, war (declared or undeclared), or any act of war and any complications there from, or service in the armed forces of any country.

Work-Related Injury or Sickness
Any injury or sickness that is caused by, or connected in any way to,employment of the covered person. (This includes self employment or employment by others. It applies whether or not workers' compensation or similar law covers the expenses incurred.)

COORDINATION OF BENEFITS

All benefits provided under the health care coverages of this Plan are subject to the following provisions and limitations, unless specifically stated otherwise.

Definitions

As used in this provision, the following terms shall have the meanings indicated:

Other Plan
"Other Plans" include benefits, services, or treatment provided by:

group, blanket, or franchise insurance coverage;

group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);

group Blue Cross and Blue Shield coverage;

group automobile insurance;

individual auto insurance based upon the principles of no-fault coverage;

any coverage under labor-management trusteed plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or

any group coverage sponsored by or provided through a school or other educational institution.

This Plan
"This Plan" shall refer to the health care coverages of this Plan.

Allowable Expense
"Allowable Expense" shall mean any Maximum Eligible Charge Incurred while the person for whom claim is made is covered under This Plan, at least a part of which is covered under any Other Plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period
"Claim Determination Period" shall mean a period that commences each January 1 and ends at 12 o'clock midnight on the next December 31, or that portion of such period during which the Claimant has been covered under This Plan.

Effect on Benefits Under This Plan

When Other Plan Does Not Contain a Coordination of Benefits Provision
As to any Claim Determination Period to which this provision is applicable, the benefits that would be payable under This Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such Allowable Expenses under This Plan and all Other Plans shall not exceed the total of such Allowable Expenses. Benefits payable under the Other Plans include benefits that would have been payable had claim been duly made for them.

When Other Plan Contains a Coordination of Benefits Provision
If the Other Plan insuring the person covered by This Plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of This Plan and would, according to its rules and the order of benefit rules below, determine its benefits after the benefits of This Plan have been determined, then the benefits of such Other Plan will not be considered for the purpose of determining the benefits due under This Plan.

If, according to the Other Plan's rules and the order of benefit rules below, This Plan is to determine its benefits after the Other Plan's benefits are determined, then the sum of all the benefits payable for Allowable Expenses under This Plan and all Other Plans shall not exceed the total of such Allowable Expenses Incurred during the Claim Determination Period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization management-type of program, This Plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, This Plan will base its coordination on the amounts that would have been paid if PPO or HMO providers had been used.

When This Plan’s PPO negotiates a specific COB provision with a particular participating provider
The Plan’s normal COB provision will be superceded by the PPO’s COB provision.

Order of Benefit Determination
The rules establishing the order of benefit determination are:

the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent;

the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee;

the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the Other Plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail;

when Claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:

(i) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or

(ii) if the Other Plan does not have the rule described above under (i), and if, as a result, the plans do not agree on the order of benefits, the rule of the Other Plan will determine the order of benefits;

when Claimant is a dependent child whose father and mother are legally separated or divorced:

the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;

the plan of the spouse of the parent with custody will be determined second; and

the plan of the parent not having custody of the child will be determined third; or

if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

Notwithstanding the foregoing, This Plan is always secondary to no-fault auto insurance coverages.

If none of the above rules establishes an order of benefit determination, the benefits of the plan that has covered the Claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under This Plan during any Claim Determination Period, each benefit that would be payable in the absence of this

provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of This Plan.

Right to Receive and Release Necessary Information
For the purpose of enforcing or determining the applicability of the terms of this provision of This Plan or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan shall furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Special Provisions with Respect to Medicare

In accordance with the Medicare Secondary Payor Act, as amended, an active Employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under This Plan. If such person elects coverage under This Plan, the benefits of This Plan shall generally be determined before any benefits provided by Medicare. However, whenever This Plan may lawfully assume a secondary position, it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When This Plan may lawfully assume a secondary position and an Employee or Dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under This Plan. An Employee or Dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner.

SUBROGATION AND REIMBURSMENT

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Covered Person may incur medical or other charges related to Injuries or Sickness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Sickness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:
Execute and deliver a Subrogation and Reimbursement Agreement;

Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise);

Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, <u>before</u> any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

Amount Subject to Subrogation or Reimbursement
Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in

full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

Another Party
Another Party shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

Another Party shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

Recovery
Recovery shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Subrogation
Subrogation shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Reimbursement
Reimbursement shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

ELIGIBLITY AND EFFECTIVE DATES

Eligibility Requirements — Employees
"Employee" shall mean a person who is a regular full-time employee of the Employer, regularly scheduled to work for the Employer in an employer-employee relationship. Such person must be scheduled to work at least 32 hours per week in order to be considered "full-time." For purposes of the Plan, seasonal, temporary and leased employees will not be deemed to be "Employees." *Anyone employed on 10/1/2008 who were working at least 20 hours per week at that time are "Grandfathered in" as eligible and will continue to be eligible for Health Insurance.*

In order to be an "Eligible Employee," so that he is eligible to participate in the health care coverages of the Plan, an Employee must complete a Waiting Period of 30 days of full-time employment. An Employee shall be deemed to be in full-time employment if he is absent from work due to a health factor. However, in order to be eligible to participate in the Plan, the Employee must begin work for his Employer. If he is unable to do so, then his coverage will become effective on such later date when he actually begins work.

Effective Date — Employees
Eligible Employees who are employed and enrolled on the effective date of the Plan and who were validly covered under the Employer's plan of health care coverage that this Plan replaces will be covered on this Plan's effective date. All other Employees will be effective as set forth above.

This Plan may provide contributory coverage (each Employee pays a part of the cost of his own coverage). An Eligible Employee's coverage is effective, subject to conditions set forth above, upon completion of the forms provided by the Contract Administrator for such purpose.

If an Employee fails to enroll within 31 days of completion of the Waiting Period, the Employee's coverage will be effective only if enrolled under the special enrollment provision or if enrolled during an open enrollment.

Eligibility Requirements — Dependents
If an Employee is covered by the Plan, the Employee's Eligible Dependents can also be covered. An "Eligible Dependent" is:

a spouse. Such spouse must be a member of the opposite sex and have met all requirements of a valid marriage contract in the state of marriage;

any child under the age of 26 (including any natural child, any legally adopted child or a child placed for adoption with Employee; a stepchild under the age of 26; a foster child or grandchild under age 26 if obtained by legal custody).

An "Eligible Dependent" does not include:

any person who is on active duty in a military service;

any person who is eligible as an Employee under the Plan;

any dependent child who is eligible for medical coverage through another employer's health plan other than a health plan of the child's parent.

any person who is covered as a Dependent of another Employee under the Plan.

Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" (QMCSO) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible

Dependent, but for purposes of the reporting and disclosure requirements an Alternate Recipient shall have the same status as a Participant.

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

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and

4. Identity of an underlying child support order.

Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or

   Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    (a) Whether the child is covered under the Plan; and
    (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Effective Date — Dependents
Subject to the Plan's special enrollment provisions, an Eligible Dependent will be covered beginning with the later of the following dates, provided the Employee makes written application for coverage for such Dependent in a form furnished by the Plan Administrator or Contract Administrator for that purpose within 30 days of Dependent's initial eligibility and the Employee has agreed to pay any required contribution for such coverage:

the date the Employee's coverage begins, provided the Employee enrolled all Eligible Dependents on or before Employee's effective date; or

the date of enrollment, if the Employee enrolls all Eligible Dependents within 30 days of Employee's eligibility date.

A Dependent's coverage will not become effective prior to the Employee's effective date. Further, any change in a Dependent's coverage will not become effective until the change in the Employee's coverage also has become effective.

Special Enrollment
If an Eligible Employee does not enroll for coverage for the Employee and/or the Employee's Eligible Dependents within thirty (30) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the Plan's special enrollment rules.

An Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

the Employee is eligible for coverage under the Plan but is not currently enrolled;

the Employee declined coverage under the Plan when it was offered previously and gave the existence of alternative health coverage as the reason for not enrolling on the Employee's enrollment form; and

the alternative coverage has terminated, because either (i) it was COBRA continuation coverage that has been exhausted, or (ii) eligibility for the alternative coverage was lost (for reasons other than the

individual's failure to pay premiums or for cause), (iii) termination of Medicaid or Children's Health Insurance Coverage (CHIP) due to loss of eligibility, (iv) employee or dependents become eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance, (v) or employer contributions toward the cost of the coverage terminated. In this case, the Employee must submit a completed enrollment form within 30 days after the date on which (1) COBRA continuation coverage was exhausted, or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in the Plan will be effective the first day of the first calendar month beginning after the date on which the Plan receives the completed enrollment form.

In addition, an Eligible Employee may enroll for coverage for the Employee and all Eligible Dependents at any time provided that:

the Employee is eligible for coverage under the Plan but is not currently enrolled;

the Employee declined coverage under the Plan when it was offered previously; and

another individual (a spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption. In this case, the Employee must submit a completed enrollment form within 31 days of the marriage, birth, adoption or placement for adoption. Enrollment in the Plan will be effective on the date (1) of the Employee's marriage; (2) of the new Dependent's birth; or (3) of the new Dependent's adoption or placement for adoption with the Employee.

Open Enrollment
Eligible Employees may enroll for coverage during Open Enrollment Periods. Coverage for Eligible Employees enrolling during an Open Enrollment Period will become effective on October 1, unless the Employee has not satisfied the Waiting Period or has not yet begun work for the Employer, in which event coverage for the Employee and his Eligible Dependents will become effective on the day following completion of the Waiting Period or the day he actually begins work. "Open Enrollment Period" shall mean the month of August in each Plan Year.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan, and one of them terminates, the terminating spouse and any of his Eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an Employee or as a Dependent of the terminated Employee.

Adjustments for Prior Coverage
To the extent that coverages hereunder are a replacement of the prior plan offered by the Employer, any Deductibles satisfied, with respect to such Covered Persons under the prior coverage, will be deemed to be Deductibles satisfied under the Plan. Any continuous periods a Covered Person was covered under prior coverage(s) of the Employer will be deemed to be time covered under the Plan. Documentation of satisfied Deductibles is the responsibility of the Covered Person.

If, on the date the prior plan is replaced with this Plan, an Employee is Totally Disabled, coverage under this Plan will be provided to the Employee and his covered Dependents, upon payment of the required contributions, in accordance with the "Extension of Coverage During Absence from Work" provision of this Plan.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under this Plan shall terminate upon the earliest of the following:

the date of termination of the Plan;

the date of termination of participation in the Plan by the Employee;

the day prior to the date of Employee's entry into the armed forces of any country;

the date of expiration of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (the Employee shares in the cost);

the date on which the covered Employee leaves or is dismissed from the employment of the Employer;

the date the Employee ceases to be eligible for coverage under the Plan; and

immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Notwithstanding the foregoing, coverage may only be retroactively terminated (1) if an Employee performs an act, practice or omission that constitutes fraud, (2) if an Employee makes an intentional misrepresentation of material fact, as determined by the Plan Administrator, or (3) as permitted under the Affordable Care Act and subsequent guidance issued thereunder. In addition, coverage may always be terminated retroactively for failure to pay contributions when due.

Dependent Coverage Termination
A Dependent's coverage under this Plan shall terminate upon the earliest of the following:

the date of termination of the Plan;

the date coverage for Dependents terminates under the Plan;

the date the Dependent becomes covered as an Employee under the Plan;

the date of termination of the coverage of the Employee;

the date the Covered Person no longer satisfies the Plan's definition of Dependent;

the date of expiration of the period for which the Employee last made the required contribution for such coverage, if the Dependent's coverage is provided on a contributory basis (the Employee shares in the cost); or

immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

See "Extension of Coverage" and "Continuation of Coverage Option (COBRA)."

Certificates of Coverage
The Plan generally will automatically provide a Certificate of Coverage to any Employee or Dependent after the individual loses coverage under the Plan. In addition, a Certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish it.

The Plan will make reasonable efforts to collect information applicable to any Dependents of the Employee and to include that information on the Certificate; however, the Plan will not issue an automatic Certificate for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan.

EXTENSION OF COVERAGE

Extension of Coverage for Handicapped Dependent Children

(Available during the continuance of the Plan only)

If an already covered Dependent Child attains the age that would otherwise terminate his status as a Dependent, and:

> if on the day immediately prior to the attainment of such age, the child was a covered Dependent under the Plan,
>
> at the time of attainment of such age, the child is incapable of self-sustaining employment by reason of mental or physical handicap, or disability that commenced prior to the attainment of such age, and
>
> such child is primarily dependent upon the Employee for support and maintenance,

then such child's status as a Dependent shall not terminate solely by reason of his having attained the specified age, and he shall continue to be considered a covered Dependent under the Plan so long as he remains in such condition and otherwise conforms to the definition of a Dependent.

The Employee must submit to the Contract Administrator proof of the child's incapacity within 31 days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage During Absence From Work

(Available during the continuance of the Plan only)

If an Employee fails to continue in active employment due to Sickness, Injury, maternity leave, temporary layoff, entry into the armed forces, fraud, termination of Dependent coverage, when Dependent becomes an Employee, if participant no longer satisfies the definition of Dependent, or approved leave of absence, the Employee may be permitted to continue health care coverages for himself and his Dependents, though Employee could be required to pay the full cost of coverage during such absence. However, in no event can the extension under this provision be longer than 12 months.

Any such extended coverage offered by the Plan and elected by the Employee shall automatically and immediately cease on the earliest of the following dates:

> the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this Plan;
>
> the date of expiration of the period for which the last contribution was paid, if such contribution is required; or
>
> the date and time of termination of this Plan.

This Plan is intended to conform to the applicable provisions of the Family Medical Leave Act of 1993 as outlined below.

Family and Medical Leave Act of 1993

A. Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), your coverage may continue during such leave. The FMLA requires any employer with fifty (50) or more employees, as defined by the Act, to maintain health coverage for an employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan. You are considered eligible for FMLA leave if you have been employed by the *employer* for at

least twelve (12) months, and have performed at least 1,250 hours of service with the *employer* in the twelve (12) months immediately preceding the start of the leave.

B. Reasons for FMLA Leave

You may continue to be covered under the Plan during an approved FMLA leave for one or more of the following reasons:

1. The birth of a son or daughter, in order to care for that son or daughter.

2. The placement of a son or daughter with you for adoption or foster care.

3. In order to care for your spouse, son, daughter, or parent who has a serious health condition unrelated to service in the line-of-duty in the Armed Forces of the United States.

4. Because of a serious health condition that makes you unable to perform the functions of your position.

5. In order to care for a member of the United States Armed Forces, including a member of the National Guard or Reserves. Military caregiver leave may be approved if it meets the following criteria:

   a. You are the spouse or the next-of-kin (the nearest blood relative of that individual) of a member of the Armed Forces who suffered a serious illness or injury in the line-of-duty while on active duty, and

   b. The Armed Forces member is undergoing medical treatment, recuperation, or therapy; is otherwise in outpatient status; or is otherwise on the temporary disability retired list and is medically unfit to perform the duties of the member's office, grade, rank, or rating.

6. A *qualifying exigency* due to your spouse, son, daughter, or parent's active duty status, or notification of an impending call to active duty status, in support of a contingency operation.

CONTINUATION OF COVERAGE OPTION

You may continue Health Expense Coverage on the Catholic Diocese of Jackson Employee Benefit Plan, which terminates for you and your dependents, for any reason, except involuntary termination of employment due to cause, but only if you have been covered under this Plan for at least 3 months in a row prior to such termination.

You must request the continuation in writing within 31 days of the later to occur of:

The date coverage would otherwise cease; and

The date your Employer provides you with the notice of your right to continue coverage.

Continuation for a person may not terminate until the earliest of:

Twelve (12) months after the date the individual's coverage would have ended because of termination of the employment;

The last date for which the individual's required premium provided coverage;

The date the individual becomes or is eligible to become covered for similar benefits under any arrangement of group coverage;

The date of which the Employer group plan is terminated;

The date of which the individual legally resides outside of the service area of an Employer's group plan;

The date a surviving spouse or former spouse of an individual remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions;

The date the individual becomes entitled to benefits under Medicare.

Coverage is **not** available to any Employee or Dependent under the following circumstances:

The individual is not covered under the Employer's Plan on the date of the Employee's termination and has not been continuously covered under the Employer's group plan for at least three (3) consecutive months prior to the date of termination of coverage under the Employer's plan;

The individual is or could be eligible for other group coverage within 31 days after coverage under this Employer Plan ends;

The Employer's Plan coverage terminated due to fraud;

The individual failed to pay required contribution for coverage under the Employer's group plan;

The individual is eligible for continuation coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985;

The individual is entitled to Medicare benefits.

Continuation Coverage under Mississippi law shall be separately available to dependent spouses and children of the Employee under the following circumstances:

In the event the Employee is deceased, written notice of the employee's death must be provided to Boon Chapman. Within 14 days of receiving notification of the death, Boon Chapman shall provide notice of the continuations privilege to the dependent spouse or the dependent children (or legal representatives of the dependent children). The dependent spouse or the dependent child has 30 days after receiving notice from Boon Chapman to elect continuation coverage under the Benefit Plan.

In the event a covered dependent child of the Employee ceases to be an eligible dependent, written notice of the date the dependent child ceased to be an eligible dependent must be provided to Boon Chapman. Within 14 days of receiving notification, Boon Chapman shall provide notice of continuation privilege to the dependent child. The dependent child has 30 days after receiving notice from Boon Chapman to elect continuation coverage under the benefit plan.

In the event of Employee's divorce from his or her dependent spouse, written notice of the date of the final divorce decree shall be provided to Boon Chapman. Within 14 days of receiving notification, Boon Chapman shall provide notice of continuation privilege to the spouse. The spouse has 30 days after receiving notice from Boon Chapman to elect continuation coverage under the benefit plan.

A dependent spouse and/or child who qualifies may elect continuation coverage for a period not to exceed 12 months after:

The date of the death of the Employee

The date of the spouse's divorce from the Employee

The date the Employee became covered under Medicare

The date the dependent child ceases to be an eligible dependent of the Employee.

A dependent spouse and/or child who elect continuation coverage under these conditions may not add any additional newly eligible dependents during special or open enrollment periods.

Premium payments must be continued. The required contribution for continued coverage may not exceed 102% of the group rate.

Certificates of Coverage

The Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan. Such certificates will be provided within the following time frames:

for an individual who is a Qualified Beneficiary entitled to elect continuation coverage, no later that when a notice is required to be provided for a Qualifying Event, as set forth above;

for an individual who is not a Qualified Beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and

for an individual who is a Qualified Beneficiary and who has elected continuation coverage, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under this provision.

CLAIMS PROCEDURES FOR DENTAL COVERAGE

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

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

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

Under the Plan, there are three types of claims: Pre-service Non-urgent, Concurrent Care and Post-service.

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

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

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

Further, since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no "Pre-service Urgent Care Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims
A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

It is important to remember that, in the event of an urgent care situation, the Covered Person need only notify CHR on the first business day after the additional stay begins. Since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

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

When Dental Claims Must Be Filed
Dental claims must be filed with the Contract Administrator within 12 months from the date on which Covered Expenses were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

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

Timing of Claim Decisions
The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Non-urgent Care Claims
If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

Concurrent Claims

Plan Notice of Reduction or Termination.
If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Request by Claimant Involving Non-urgent Care
If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

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

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

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

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

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

Notification of an Adverse Benefit Determination
The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures following an adverse benefit determination on final review;
5. 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 for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request); and
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a dental care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a 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 in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances

Requirements for Appeal

The Claimant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows: Pre-service Non-urgent Claims – Prime Dx, P.O. Box 9201, Austin, Texas 78766, fax number (512) 454-1624 or Post-service Claims – Boon-Chapman Benefit Administrators, Inc., Attention: Appeals, P.O. Box 9201, Austin, Texas 78766 Fax Number: 512-459-1552.

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

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

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

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims
The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims
Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review.
The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. 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 for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
7. A statement of the Claimant's right to bring an action, following an adverse benefit determination on final review; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination.
In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form, which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

DEFINITIONS

When used in this Plan Document, the following items shall have the meanings shown below. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

Accidental Injury
Any accidental bodily Injury that occurs while an individual is covered under the Plan and that is caused by external forces under unexpected circumstances and that does not arise out of or in the course of the employment of the Covered Person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching are not considered Accidental Injuries.

Active Course of Orthodontic Treatment
The period of time which begins when the first orthodontic appliance is installed and ends when the last active appliance is removed.

Calendar Year
The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:00 midnight on the next December 31. Each succeeding like period will be considered a new Calendar Year.

Calendar Year Maximum Benefit
The most benefits the Plan will pay for Covered Expenses of a Covered Person Incurred during a Calendar Year.

Certificate of Coverage
A written certification provided by any source that offers medical care coverage, including this Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Claimant
Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Co-insurance
See the Schedule of Benefits.

Contract Administrator
The company that provides claims adjudication and other ministerial services to the Plan in accordance with an administrative services agreement between the Contract Administrator and the Employer.

Co-payment or Co-pay
The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible or the Annual Out-of-Pocket Maximums.

Covered Expense
An expense incurred by a Covered Person that is payable by the Plan as Co-insurance or is payable by the Covered Person as a deductible, as Co-insurance, as a Co-payment, or because of a benefit.

Covered Person
A covered Employee, a covered Dependent, or a COBRA Qualified Beneficiary.

Creditable Coverage
Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

Deductible
See the Schedule of Benefits for information.

Dental Hygienist
A person who is licensed to practice dental hygiene, practicing within the scope of his or her license, and not a member of your Immediate Family.

Dental Practitioner
A Dentist, Dental Hygienist, or Denturist.

Dentist
A person who is licensed to practice dentistry or Oral Surgery, practicing within the scope of his or her license, and not a member of your Immediate Family.

Denturist
A person who is licensed to make, fit, or repair dentures, practicing within the scope of his or her license, and not a member of your Immediate Family.

Dependent
See "Eligibility and Effective Dates."

Employee
See "Eligibility and Effective Dates."

Employer
The entities listed in "Administrative Information" as participating employers.

Immediate Family
You, your spouse, and the children, brothers, sisters, and parents of you and your spouse.

Incurred
Expenses shall be deemed to be "Incurred" on the latest of the following dates:

the date a purchase is contracted;

the date delivery is made; or

the actual date a service is rendered.

With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

With respect to dental services, expenses shall be deemed to be "Incurred" on the date that the service or treatment is performed, exept for the following services or treatments:

dentures or bridgework – the date the impressions are taken;

crowns, inlays, onlays, - the date the teeth are first prepared;

root canal therapy – the date the pulp chamber is opened; and

active orthodontic care – the date the appliances are inserted.

Injury
A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Late Enrollee
An individual who is allowed to enroll in the Plan, other than during the period of initial eligibility or during a special enrollment eligibility period.

Maximum Eligible Charge
Maximum Eligible Charge is an amount determined in the discretion of the Plan Administrator or its delegate using any one of the following:

- A fee that was negotiated with the Provider;
- A fee determined using a national relative value scale;
- A fee determined using a percentage of what Medicare would allow for the service or supply;
- A fee determined using a commercial healthcare database;
- A fee determined using a percentage off of billed charges; or
- A fee determined using other relevant information.

With regard to charges made by a provider of service participating in the Plan's PPO program, "Maximum Eligible Charge" shall mean the rates negotiated between the preferred provider organization and the participating providers.

Medically Necessary or Medical Necessity
When a service, treatment, device, drug, or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

be rendered in connection with an Injury or Illness;

be consistent with the diagnosis and treatment of your condition; and

be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate. Medically Necessary is the criteria by which the Plan Administrator determines the necessity of medical service and treatment under this Plan.

A service, treatment, device, drug, or supply will not be considered Medically Necessary if:

it is provided only as a convenience to the Covered Person or provider;

it is not appropriate treatment for the Covered Person's diagnosis or symptoms;

it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;

it is part of a plan of treatment that is considered to be Investigative, Experimental or for Research Purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, Experimental or for Research Purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or

it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required, or if it involves the use of a drug or substance that cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;

is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or

is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The fact that any particular Physician may prescribe, order, recommend or approve a service, treatment, device, drug or supply does not, of itself, make it Medically Necessary.

The sources of information to be relied upon are:

the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular Injury or Sickness at issue;

a Covered Person's medical records;

protocol pursuant to which the treatments is to be delivered; or

any regulations and publications set forth by any governmental agency.

Medicare
Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Oral Surgery
Medically Necessary procedures for Surgery in the oral cavity, including pre- and post-operative care.

Orthodontic Treatment
The movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Outpatient
Services rendered on other than an Inpatient basis.

Plan
The Catholic Diocese of Jackson Employee Health Protection Plan

Plan Administrator
See "Administrative Information" Section.

Plan Document
This Plan Document and Summary Plan Description, which shall serve as both the Plan Document and the Summary Plan Description.

Plan Sponsor
See "Administrative Information" Section.

Plan Year
A period of time commencing at 12:01 a.m. on the effective date, or any anniversary of the effective date, of this Plan and continuing until the next succeeding anniversary.

Prosthesis
An artificial device to replace a missing part of the body or to aid the function of a bodily organ.

Protected Health Information (PHI)
Any information that identifies an individual, or reasonably could be used to identify an individual.

Significant Break in Coverage
A period of 63 consecutive days during all of which an individual did not have any Creditable Coverage, but does not include a Waiting Period or an Affiliation Period.

Spouse
A person of the opposite sex who is a husband or wife.

Surgery
Any operative or diagnostic procedure performed in the treatment of an Injury or Illness by instrument or cutting procedure through any natural body opening or incision.

Temporomandibular Joint Dysfunction
Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

Waiting Period
The period that must pass before an Employee or Dependent can become effective under the terms of a group health plan. If an Employee or Dependent enrolls as a Late Enrollee or on a special enrollment date, any period before such late or special enrollment is not a Waiting Period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a Waiting Period.

GENERAL PLAN INFORMATION

Funding - Sources and Uses

Employee Obligations
The health care coverage afforded to an Employee by this Plan shall be at least partially funded by the Plan Sponsor. If an Employee elects to enroll Dependents under the Plan, the Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer shall deduct such costs on a regular basis from the Employee's wages or salary.

Plan Sponsor Obligations
The Plan Sponsor shall also make contributions to the Plan for health care coverage. These contributions and those paid by Employee, if any, shall be placed in a special account or accounts administered by the Contract Administrator.

Use of Contributions
The contributions will be applied to provide the benefits under the Plan. Contributions may be used to purchase insurance coverage to ensure that the Plan will meet its self-funded health care coverage obligations. The policy may be reviewed upon request submitted to the Contract Administrator. The Contract Administrator is also available to answer any questions about the coverages. The provisions of this Plan Document in no way modify those of any insurance policy. Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Employer and the Contract Administrator.

Amount of Contributions
The Plan Sponsor shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Plan Sponsor and by Employees (if any).

Taxes
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan shall be paid by the Plan Sponsor.

Administrative Provisions

Administration
The benefits of the Plan are administered by one or more Contract Administrators under the terms and conditions of administration agreements between the Employer and Contract Administrator.

Alternative Care
In addition to the benefits specified herein, the Plan Administrator has the discretion to provide benefits that would not otherwise be payable when and for so long as it determines that such benefits are less than the benefits the Plan would have to pay if it did not pay them.

If the Plan Administrator decides to pay such benefits in one instance, it shall not be obligated to provide the same or similar benefits in any other instance, nor shall such action be deemed to be a continuing waiver unless specifically stated therein.

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan

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

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether a Medical Child Support Order or National Medical Support Notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or any trust agreement.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

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

Annual Statements
If required by law, the Plan Sponsor shall furnish to each Employee, within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

Anticipation, Alienation, Sale, or Transfer
No benefit payable under the provisions of the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt to so anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of or claims against any Covered Person, including claims of creditors, claims for alimony or support, or any like or unlike claims.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

Entire Contract
The Plan Document, any amendments, and the individual applications, if any, of Covered Persons shall constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any employee. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any employee or person any legal or equitable rights against the Plan Sponsor, the Plan Administrator, or their respective shareholders, directors or officers.

Facility of Payment
Every person receiving or claiming benefits under the Plan shall be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator determines that an Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan Administrator with an address at which he can be located for payment, the Plan Administrator may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee to the husband, wife, or relative by blood of the Employee or to any other person or institution determined by the Plan Administrator to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan Administrator may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brother, or sister, or to the Employee's estate, as the Plan Administrator in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Plan.

If a guardian, conservator, or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments shall be made to such guardian, conservator, or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Plan Administrator. To the extent permitted by law, any such payment so made shall be a complete discharge of any liability therefore under the Plan.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of God, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

Fraud
The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire family unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Free Choice of Physician
Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology shall also include the feminine, and the definition of any term in the singular shall also include the plural.

Illegality of Particular Provision
The illegality of any particular provision of this Plan Document shall not affect the other provisions, but this Plan Document shall be construed in all respects as if such invalid provision were omitted.

Legal Actions
Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to the Injury or Sickness are Incurred or are alleged to have been Incurred. Any limitation on actions regarding claims for benefits shall be as provided in the section entitled "Claim Procedures for Health Care Coverage."

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Physical Examination and Autopsy
The Plan Administrator, at its own expense, shall have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim and to make an autopsy in case of death, where it is not forbidden by law.

Reimbursements
Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor shall be authorized to pay such benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan shall be fully discharged from liability for such payments to the full extent thereof.

Right of Recovery
Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of this Plan Document, the Plan Administrator shall have the right to recover all such excess amounts from any persons, insurance companies, or other payees, and the Covered Person shall make a good-faith attempt to assist in such recovery. Further, the Plan Administrator shall have the right to recover any excess payments from any future benefits payable to the Employee or his Dependents.

The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent such care or services have been provided, the Plan shall be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person or his parent or guardian shall execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Administrator for the purpose of enforcing its rights under this provision.

Titles or Headings
Titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of its provisions.

Type of Plan
This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for Eligible Employees of the Employer, their Eligible Dependents, and Qualified Beneficiaries under COBRA.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws or similar legislation.

HIPAA PRIVACY RULE AND SECURITY STANDARDS

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the "504" provisions") which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

The Plan's Designation of Person/Entity to Act on its Behalf
The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates {*insert name of designated person or entity, such as the Plan Administration Committee (or a member thereof), or the Plan sponsor*} to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (*e.g.,* entering into business associate contracts; accepting certification from the Plan sponsor).

The Plan's disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor
Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the "504" provisions;

2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and

3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

Permitted disclosure of members' Protected Health Information to the Plan sponsor
The Plan (and any health insurance issuer or HMO servicing the Plan) will disclose members' Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan's members by a health insurance issuer or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members' Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will not use or further disclose members' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members' Protected Health Information received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

The Plan sponsor will not use or disclose members' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.
The Plan sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan sponsor becomes aware.

Disclosure of members' Protected Health Information – Disclosure by the Plan sponsor
The Plan sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. § 164.524.

The Plan sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of members' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to members' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Benefits Coordinator

2. Chief Financial Officer

This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive members' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

Security Standards

Plan Sponsor Obligations

Where Electronic Protected health Information will be created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates received, maintains, or transmits on behalf of the Plan;

B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as descried below:

    1. Plan sponsor shall report to the plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every month, or more frequently upon the Plan's request.