

DENTAL PLAN

MASTER PLAN DOCUMENT

HR AMERICA, INC.

EFFECTIVE DATE OF THE PLAN: AUGUST 1, 2003

HR AMERICA, INC.

**MASTER PLAN DOCUMENT FOR SELF-FUNDED
GROUP DENTAL BENEFITS**

To be effective **August 1, 2003, HR America, Inc.** adopts this Master Plan Document which includes Group Dental Benefits.

HR America, Inc. adopts and accepts this Master Plan Document.

Date

Signature

Print or Type Name

Witness Name

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	5
DENTAL BENEFITS.....	5
<i>Individual Deductible</i>	5
<i>Family Deductible Limit</i>	5
<i>Calendar Year Maximum</i>	5
<i>Class I - Preventive Services</i>	5
<i>Class II - Basic Services</i>	5
<i>Class III - Major Services</i>	5
<i>Class IV - Orthodontia Services</i>	6
<i>Maximum Benefit - Orthodontia</i>	6
ELIGIBILITY FOR COVERAGE	7
ELIGIBILITY PROVISIONS.....	7
<i>Eligible Employees</i>	7
<i>Eligible Dependents</i>	7
EFFECTIVE DATE OF COVERAGE	10
EFFECTIVE DATE OF COVERAGE	10
PLAN PARTICIPATION	10
TRANSFER OF STATUS	10
SPECIAL ENROLLMENT PROVISIONS	10
<i>Loss of Coverage</i>	10
<i>Family Status Change</i>	12
MISCELLANEOUS ENROLLMENT PROVISIONS	12
<i>Annual Open Enrollment</i>	12
<i>Legal Guardianship</i>	13
<i>Qualified Medical Child Support Order</i>	13
<i>Paternity</i>	13
EXTENSION OF ACTIVE SERVICE PROVISIONS	14
<i>Approved Personal/Medical Leave of Absence</i>	14
<i>Family and Medical Leave Act of 1993</i>	14
<i>Layoff</i>	14
REINSTATEMENT PROVISIONS	15
<i>Reinstatement of Coverage</i>	15
<i>Full-time Student Reinstatement of Coverage</i>	15
<i>Uniformed Service Employment and Reemployment Rights Act (USERRA)</i>	15
TERMINATION OF COVERAGE	17
CONTINUATION OF COVERAGE (COBRA)	18
DENTAL BENEFITS	26
PRE-CERTIFICATION OF BENEFITS	26
CLASS I - PREVENTIVE SERVICES	26
CLASS II - BASIC SERVICES.....	26
CLASS III - MAJOR SERVICES	27
CLASS IV - ORTHODONTIA SERVICES	28
EXTENSION OF DENTAL BENEFITS.....	28
LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN	29

TABLE OF CONTENTS

COORDINATION OF BENEFITS	32
DEFINITIONS.....	32
EFFECT ON BENEFITS.....	33
ORDER OF BENEFITS DETERMINATION	33
RIGHT TO NECESSARY INFORMATION	34
COORDINATION OF BENEFITS WITH MEDICARE	34
FACILITY OF PAYMENT.....	34
HOW TO FILE A CLAIM	35
GENERAL TERMS AND DEFINITIONS	36
GENERAL INFORMATION	40
ADMINISTRATION OF THE PLAN.....	40
BENEFIT CLAIM PROCEDURES AND APPEAL PROCEDURES FOR CLAIMS	40
CALCULATION OF PLAN MAXIMUM AMOUNTS.....	45
CLERICAL ERROR	45
CONFORMITY WITH GOVERNMENT LAW.....	45
COST SHARING PROVISIONS	45
DUPLICATION OF BENEFITS	45
FINANCING AND ADMINISTRATION.....	45
MASTER PLAN DOCUMENT.....	46
MEDICAL CARE PROVIDED BY THE UNITED STATES.....	46
NEW DRUGS, MEDICAL TESTS, DEVICES AND PROCEDURES.....	46
PARTICIPANT CONTRIBUTION.....	46
PAYMENTS DIRECTLY TO PROVIDERS	46
PLAN AMENDMENT OR TERMINATION.....	46
PLAN INTERPRETATION	47
PLAN IS NOT A CONTRACT	47
PLAN MAXIMUMS AND BENEFIT MAXIMUMS.....	47
PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT	47
PRESUMPTION OF RECEIPT OF INFORMATION	49
PROOF OF CLAIM.....	49
RESCISSION OF COVERAGE.....	50
RIGHT OF RECOVERY FOR PAYMENTS MADE.....	50
RIGHTS WITH RESPECT TO MEDICAID	50
SELF-FUNDING.....	50
SUMMARY PLAN DESCRIPTIONS	51
USUAL AND CUSTOMARY PROCEDURE.....	51
WORKERS' COMPENSATION.....	51
PLAN INFORMATION	52
STATEMENT OF ERISA RIGHTS	53
APPENDIX - PREFERRED PROVIDER ORGANIZATION (PPO) QUESTIONNAIRE	

SCHEDULE OF BENEFITS

The outline of benefits in this schedule is a summary of coverage provided by the Plan. A detailed explanation of the benefits is provided in the pages which follow.

Benefits listed in the Plan are limited to the Usual and Customary fees and subject to the Limitations and Exclusions specified in the Plan.

Dental Benefits

Individual Deductible

\$50.00 per person per calendar year

Family Deductible Limit

\$150.00 per family per calendar year

Eligible charges for family members who are covered under the Plan may be applied toward satisfaction of the family deductible limit. However, no more than \$50.00 from any one individual will be applied toward the family deductible limit.

Calendar Year Maximum

First Calendar Year of Coverage for Late Enrollees and Timely Add-Ons: \$500.00

Subsequent Calendar Years: \$1,000.00 per person per calendar year

Class I - Preventive Services

- The deductible amount does not apply
- Amount paid by the Plan: 100%

Class II - Basic Services

- The deductible amount applies
- Amount paid by the Plan: 80%

Class III - Major Services

- The deductible amount applies
- Amount paid by the Plan: 50%

SCHEDULE OF BENEFITS

Class IV - Orthodontia Services

- A \$50.00 orthodontia deductible applies. This is separate and not in addition to the dental deductible.
- Amount paid by the Plan: 50%
- Limited to covered dependents until age 19

Maximum Benefit - Orthodontia

\$1,000.00 per person while covered by the Plan

ELIGIBILITY FOR COVERAGE

Eligibility Provisions

Eligible Employees

All full-time employees actively at work and working 30 or more hours per week, 48 weeks per year on a regular basis for the employer are eligible for coverage under the Plan. Temporary, seasonal, part-time, independent contractors, leased (even if determined to be common-law employees) and retired employees are not eligible for coverage.

Eligible Dependents

Eligible dependents include the following:

1. a lawful spouse of the employee;
2. each unmarried Child (as defined in subparagraphs a-e below) of the covered employee who is less than age 19 or who is at least age 19 but less than age 24 and meets the requirements of the “Full-time Student” provision specified below. Unless otherwise required by court order or divorce decree, the covered employee must provide financial support and maintenance to the child as defined by the United States Internal Revenue Code and each child must qualify as a dependent by that definition in the current year or on the most recently filed Federal Income Tax Return. “Child” shall mean:
 - (a) a natural born son or daughter of the covered employee;
 - (b) a child for whom the covered employee has been appointed guardian by court order or a stepchild, provided the employee meets the support and maintenance requirements for the stepchild or ward as specified above and provided the stepchild or ward has not attained the limiting age requirements as specified above;
 - (c) a child who meets the requirements of the Handicapped Child provision specified below;
 - (d) a child who meets the requirements of the Adopted Child provision specified below; or
 - (e) a child who meets the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order provision specified below.

Full-time Student

A child is eligible for coverage under the Plan if he or she is attending an accredited school, college or university on a full-time basis. Full-time student status will be determined based upon the rules of the school, college or university.

A child who is an active full-time student on the day immediately prior to the end of a school term or semester may continue coverage under the Plan for a period not to exceed 120 days from the date on which the school’s semester or term ended. If the child does

ELIGIBILITY FOR COVERAGE

not return to a school, college or university as a full-time student within the 120 day time period specified above, then coverage under the Plan will terminate at the end of the month in which the 120 day period ended. The dependent may, in certain instances, be eligible to continue coverage through the Continuation of Coverage (COBRA) provision.

If a full-time student loses full-time student status during a school semester or term, then coverage under the Plan will terminate at the end of the month in which the child lost full-time student status. The dependent may, in certain instances, be eligible to continue coverage through the Continuation of Coverage (COBRA) provision.

Handicapped Child

A natural born child, an adopted child, a step-child or a child for whom the covered employee has been appointed guardian by court order who loses coverage under the Plan due to the child attaining an age that would terminate the child's coverage under the Plan, may continue coverage under the Plan if and so long as the child meets all of the requirements as specified below:

1. the child has a mental or physical handicap that makes the child incapable of self-sustaining employment;
2. the covered employee who is the child's parent, step-parent or guardian provides at least 50% support and maintenance to the child;
3. the child meets all other eligibility requirements of the Plan;
4. the covered employee who is the child's parent, step-parent or guardian is actively at work with the employer;
5. the child is unmarried; and
6. the child is covered as a dependent on the Plan on the day immediately prior to the date on which the child would lose coverage as a result of having attained an age which would otherwise make the child ineligible for coverage.

The child or the child's parent, step-parent or guardian shall provide satisfactory proof to the Plan Administrator that the conditions described above existed on the date the child would otherwise lose coverage as a result of having attained an age which would otherwise make the child ineligible for coverage. Such proof shall not be requested more than annually after the date the first proof was provided. If satisfactory proof is not submitted when it is due, the child's coverage will terminate on that date.

Adopted Child

Dependent children placed for adoption with a covered employee shall be eligible for coverage under the same terms and conditions as apply in the case of dependent children who are natural born children of covered persons under the Plan, irrespective of whether the adoption has become final.

As used in this section "Adopted Child" only, the term "child" means, in connection with any adoption, or placement for adoption of a child, an individual who has not attained age 18 as of the date of such adoption or placement for adoption.

ELIGIBILITY FOR COVERAGE

The terms "placement" or "being placed" for adoption in connection with any placement for adoption of a child with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such person terminates upon the termination of such legal obligation.

Coverage Pursuant to a Qualified Medical Child Support Order

The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian.

The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" shall have the meanings given to them in Section 609 of the Employee Retirement Income Security Act.

An "Alternate Recipient" shall mean any child of a covered person who is recognized under a Medical Child Support Order as having a right to enroll under the Plan with respect to such covered person.

A copy of the Qualified Medical Child Support Order procedures may be obtained without charge from the employer.

EFFECTIVE DATE OF COVERAGE

Effective Date of Coverage

Each employee who is an eligible employee and such employee's eligible dependents may become effective for coverage:

Type I Companies – first day of the month following the first day of employment for the employer as an eligible employee.

Type II Companies - first day of the month following 30 days of employment for the employer as an eligible employee.

Type III Companies - first day of the month following 60 days of employment for the employer as an eligible employee.

Type IV Companies - first day of the month following 90 days of employment for the employer as an eligible employee.

Written application to elect coverage under the Plan must be made no later than 31 days after the effective date of coverage. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Plan Participation

An eligible dependent cannot be covered under the Plan, unless the employee who is the dependent's spouse, parent, step parent or guardian is covered as an employee under the Plan or unless coverage is provided pursuant to an extension of coverage provision as provided in the Plan. However, this restriction does not apply to individuals properly electing COBRA coverage under the Plan. An eligible dependent cannot be covered under the Plan by more than one eligible employee. Also, an employee cannot be covered under the Plan as both an eligible employee and as an eligible dependent.

Transfer of Status

An individual who is covered under this Plan as either an employee or as a dependent may transfer to dependent or employee status under this Plan provided the individual is eligible for that coverage under this Plan and provided a lapse in coverage did not occur. In this instance, the waiting period shall not apply.

Special Enrollment Provisions

Loss of Coverage

An eligible dependent of a covered employee or an employee who is eligible for coverage under the Plan, may be permitted to enroll for coverage under the Plan if:

EFFECTIVE DATE OF COVERAGE

1. the employee stated in writing at the time that coverage was declined or terminated under this Plan that other coverage under the type of coverage described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan was the reason for declining enrollment or terminating coverage under this Plan, but only if at such time the Plan required such a written statement and the Plan provided the employee with notice of the requirement (and the consequences of the requirement);
2. the employee or dependent at the time coverage under this Plan was declined or terminated by the employee or dependent:
 - a) was covered under a COBRA continuation provision and the coverage under such provision terminated for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan; or
 - b) was not covered under a COBRA continuation provision and either the coverage under the type of coverage described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan was terminated as a result of:
 - loss of eligibility for coverage (including loss of eligibility for coverage as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment); or
 - employer contributions toward such coverage were terminated; or
 - the exhaustion of COBRA coverage if elected following such loss of eligibility under the type of coverage described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan; and
3. provided the employee or dependent makes written application for coverage under the Plan no later than 31 days following the loss of coverage as described in 2(a) or (b) above.

Additionally, the employee or dependent must provide acceptable written evidence that health coverage under the type of coverage described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan existed, the names of the individuals who were covered under such group health plan, the level of coverage under the type of coverage described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan (individual or family), type of coverage (medical, dental, etc.) and the date the coverage terminated. Any applicable waiting period for coverage under the Plan must be satisfied before coverage becomes effective.

In such instances, coverage may become effective on the day after coverage under the other previous type of coverage as described in the definition of Creditable Coverage as defined in the General Terms and Definitions section of the Plan terminated and such person will not be considered a Late Enrollee as specified in the General Terms and Definitions section of the Plan.

EFFECTIVE DATE OF COVERAGE

If coverage is not available under this Loss of Coverage provision, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Family Status Change

An eligible dependent of a covered employee or an employee who is eligible for coverage under the Plan, may be permitted to enroll for coverage under the Plan if:

1. the employee is a covered person or the employee has met any waiting period applicable to becoming covered under the Plan and is eligible to be enrolled in the Plan, but when previously eligible, had declined enrollment for coverage under the Plan; and
2. a person becomes a dependent of the employee through marriage, birth, adoption or placement for adoption

then, the dependent acquired through marriage, birth, adoption or placement for adoption (and, if not otherwise enrolled, the employee) may be covered under the Plan as a dependent of the employee.

A dependent of the covered employee who was not covered under the Plan on the date of birth, placement for adoption or adoption of the employee's acquired dependent child, may be covered under the Plan if the dependent is otherwise eligible for coverage.

In these instances, written application to elect coverage under the Plan must be made within 31 days after the date of marriage, birth, adoption or placement for adoption. If coverage under the Plan is elected within this time period, coverage may become effective on the date of such marriage, birth, adoption or placement for adoption and such person will not be considered a Late Enrollee as specified in the General Terms and Definitions section of the Plan. If the employee has family coverage in effect on the date of birth of the employee's natural child, then such child may become effective for coverage on the date of birth and the requirement to make written application for coverage for the newborn child shall not apply. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Miscellaneous Enrollment Provisions

Annual Open Enrollment

During the December open enrollment period which is presently provided each calendar year:

1. a covered employee may make written application to elect coverage under the Plan for an eligible dependent; or

EFFECTIVE DATE OF COVERAGE

2. an eligible employee may make written application to elect coverage under the Plan for himself or herself and any eligible dependents provided the employee has met any applicable waiting period prior to becoming covered under the Plan.

The effective date of coverage will be January 1 following the enrollment period. However, written application to elect coverage under the Plan may be made outside the open enrollment period as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Legal Guardianship

An eligible dependent child may become covered under the Plan on the date on which such child is placed in the covered employee's home pursuant to a court order appointing the covered employee as legal guardian for the child. The employee must make written application to elect coverage under the Plan within 31 days of the date on which the child is placed in the employee's home pursuant to a court order appointing the employee as legal guardian for the child. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Qualified Medical Child Support Order

An eligible dependent child may become covered under the Plan on the date on which coverage is required to become effective pursuant to a Qualified Medical Child Support Order.

Paternity

Children born outside of marriage may become eligible dependents of a covered employee who is the father. The employee must make written application to elect coverage under the Plan within 31 days of:

1. the date of a court order declaring paternity; or
2. the date the acknowledgment of paternity is filed with the Department of Health and Social Services or its equivalent is filed with the equivalent agency in another state.

If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll such child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Extension of Active Service Provisions

Approved Personal/Medical Leave of Absence

If a personal or medical leave of absence is approved by the employer, coverage may continue during the leave of absence to a maximum of 90 days from the date on which the leave began. If the employee does not return to full-time employment within 90 days following the date on which the leave began or upon expiration of the approved leave, whichever is the earlier to occur, coverage under the Plan will terminate. The employee may, in certain instances, be eligible to continue coverage through the Continuation of Coverage (COBRA) provision. The "Approved Personal/Medical Leave of Absence" runs concurrently with other extensions of coverage within the Extension of Active Service Provisions.

Family and Medical Leave Act of 1993

Employees who are covered under the Plan and who have been granted leave ("Leave") pursuant to the Family and Medical Leave Act of 1993 (the "Act"), will have coverage under the Plan for the duration of the Leave at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of the Leave.

During a Leave, an employee's participation in the Plan may terminate as a result of non-payment of the employee contribution required in order to participate in the Plan. Upon the eligible employee's timely return from Leave as specified by the employer, the employee's coverage under the Plan (including coverage for eligible dependents if covered under the Plan at the time coverage terminated) will become effective on the date of the eligible employee's actual return to work, provided written application to elect coverage under the Plan is made within 31 days of the date the employee returned to work. In such instances the waiting period will not apply. However, the Plan will not be required to pay for any charges incurred during the period in which coverage was terminated under the Plan. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Layoff

If an employee is laid off by the employer, coverage may continue during the layoff to a maximum of 30 days from the date on which the layoff began. If the employee does not return to full-time employment within 30 days following the date on which the layoff began or upon expiration of the layoff, whichever is the earlier to occur, coverage under the Plan will terminate. The employee may, in certain instances, be eligible to continue coverage through the Continuation of Coverage (COBRA) provision.

Reinstatement Provisions

Reinstatement of Coverage

If an employee's coverage has terminated for any reason, and if that person is receiving benefits under the Plan pursuant to the Continuation of Coverage (COBRA) provision, coverage will become effective on the first day of reemployment as an eligible employee provided there has been no lapse in coverage. In such instances, the waiting period will not apply. Coverage under the Plan will become effective on the date of return to active employment as an eligible employee. The employee must make written application to elect coverage under the Plan within 31 days following the date of return to active employment. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Full-time Student Reinstatement of Coverage

A dependent child of a covered employee may be reinstated for coverage under the Plan, if the child's coverage under the Plan terminated because the child ceased to meet the requirements of the Plan's Full-time Student provision and subsequently the child regains status as an eligible full-time student and satisfies the other eligibility requirements of the Plan. Coverage under the Plan will become effective on the date on which the child is enrolled and accepted as a full-time student by the school, college or university. Written application for coverage must be made within 31 days of the date on which the child becomes an eligible full-time student. If coverage under the Plan is elected after the time period specified above, the employee may, in certain instances, be eligible to enroll the dependent child for coverage under the Plan as specified in the Special Enrollment Provisions and Miscellaneous Enrollment Provisions of the Plan.

Uniformed Service Employment and Reemployment Rights Act (USERRA)

The Uniformed Service Employment and Reemployment Rights Act (USERRA) is a federal law, effective October 13, 1994. The law requires that all employers provide a cumulative total of five years, and in certain instances more than five years, of military leave during an employee's employment with the employer.

Continuation of Coverage During a Military Leave

The law requires that an employer continue to provide coverage under this Plan during a military leave that is covered by the Act for you or your dependents. The coverage provided must be identical to the coverage provided under the employer's plan to similarly situated, active employees and dependents. This means that if the coverage for similarly situated, active employees and dependents is modified, coverage for the individual on military leave will be modified. The cost of such coverage will be:

1. For military leaves of 30 days or less, the same as the employee contribution required for active employees;
2. For military leaves of 31 days or more, up to 102% of the full cost of the coverage, e.g., the employee and employer share.

EFFECTIVE DATE OF COVERAGE

Continuation coverage rights apply to medical, dental, prescription drug and other health coverages. Short and long term disability and life benefits are not subject to continuation rights.

Continued coverage provided under USERRA will reduce any continuation provided under COBRA.

Maximum Period of Coverage During Military Leave

Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to return to Employment with the Company following completion of your military leave. Employees must return to employment within:
 - a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service.
 - b) 14 days after completing military service for leaves of 31 to 180 days,
 - c) 90 days after completing military service, for leave of more than 180 days; or
2. 18 months from the date your leave began.

Reinstatement of Coverage Following Military Leave

The law also requires, regardless of whether continuation coverage as stated above was elected, that your coverage and your dependents coverage be reinstated immediately upon your honorable discharge from military service and return to employment, if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. 14 days of completing your military service, for leaves of 31 to 180 days; or
3. 90 days of completing your military service, for leaves of more than 180 days.

If, due to a sickness or injury caused or aggravated by your military service, you cannot return to work within the times stated above, you may take up to a period of two years, or as soon as reasonably possible if for reasons beyond your control you cannot return within two years, to recover from such sickness or injury and return to employment within the times stated above.

If your coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continual under the Plan. The eligibility period will be waived.

This waiver of limitations does not provide coverage for any sickness or injury caused or aggravated by your military service, as determined by the Secretary of Veterans Affairs.

TERMINATION OF COVERAGE

An employee's or dependent's coverage will terminate upon the earliest of the following occurrences:

- 1.** the end of the month following the date of termination of the employee's employment;
- 2.** the end of the month following the date on which the employee or dependent cease to be in a class eligible for coverage;
- 3.** the effective date on which a modification of the Plan terminates coverage for the class of employees or dependents to which the employee or dependent belongs;
- 4.** the date of termination of the Plan;
- 5.** the date on which the employee designates to terminate coverage under the Plan;
- 6.** the end of the period for which a contribution for coverage has been paid if the contribution for the next period is not paid when due;
- 7.** the date on which a covered person enters service in the Uniformed Services on an active duty basis, other than for scheduled drills or other training of less than 31 days, unless coverage continuation has been elected under the Uniformed Services Continuation and Reinstatement;
- 8.** the end of the month following the date on which the employee or dependent no longer meet the eligibility requirements of the Plan;
- 9.** the end of the month following the date on which a dependent ceases to meet the definition of a dependent;
- 10. a)** the date on which any extension of coverage (including a leave of absence) as described in the Extension of Active Service Provisions of the Plan expires; or
b) for any extension of coverage (including a leave of absence) as described in the Plan which runs concurrently with the Continuation of Coverage (COBRA) provision, coverage will end on the date the extension of coverage (including a leave of absence) begins, unless otherwise specified in such provision;
- 11.** as to any particular benefit, the effective date on which coverage for the benefit is eliminated by amendment to the Plan; or
- 12.** the date as stated in the provision entitled "Rescission of Coverage" in the General Information section of the Plan.

CONTINUATION OF COVERAGE (COBRA)

On April 7, 1986, a Federal Law was enacted ("COBRA") requiring most employers sponsoring group health benefit plans to offer employees and/or their dependents the opportunity for temporary COBRA continuation coverage under their group health plan (referred to as "COBRA continuation coverage").

Definitions

For purposes of this COBRA Section the following terms shall have the following meanings.

1. *Covered Employee.* A Covered Employee is an employee or former employee who was covered by the Plan the day before a Qualifying Event.
2. *Covered Dependent.* A Covered Dependent is a "Dependent", as that word is defined in the Plan, covered by the Plan the day before a Qualifying Event, including children born to or placed for adoption with a Covered Employee at any time during the COBRA continuation coverage period for whom coverage is elected in accordance with the requirements of the Plan.
3. *Loss of Coverage.* Loss of Coverage means to cease to be covered under the Plan or to cease to be covered under the terms and conditions in effect immediately before the Qualifying Event, including an increase in employee premium or contribution resulting from a Qualifying Event. (Note: The actual Loss of Coverage need not occur at the same time as the Qualifying Event. It is sufficient that the Loss of Coverage occurs any time before the end of the maximum coverage period.)

Eligibility for Continuation

In order to be eligible to elect COBRA continuation coverage, an individual must be a Qualified Beneficiary who meets the requirements of 1, 2, or 3 below and who experiences a Loss of Coverage due to a Qualifying Event.

A Qualified Beneficiary is:

1. any individual who, on the day before a Qualifying Event, is covered under the Plan either as a Covered Employee, the spouse of a Covered Employee, or the dependent child of a Covered Employee; or
2. any child born to or placed for adoption with, a Covered Employee during a period of COBRA continuation coverage; or
3. (for the Qualifying Event of the bankruptcy of the employer) a Covered Employee who retired on or before the date of any substantial elimination of coverage under the Plan is a Qualified Beneficiary; the spouse, surviving spouse, or dependent child of the retired Covered Employee also is a Qualified Beneficiary if the spouse, surviving spouse, or dependent child was covered under the Plan on the day before the bankruptcy.

Note: A Qualified Beneficiary can never be 1.) a non-resident alien of the United States with no U.S. income; or 2.) an individual who is not otherwise a Qualified Beneficiary who became covered under the Plan because of another Qualified Beneficiary's election for coverage; 3.) any person (other than a newborn or newly adopted child) who was not covered under the Plan on the date before the Qualifying Event; 4.) a person who marries a Covered Employee during a

CONTINUATION OF COVERAGE (COBRA)

COBRA continuation period; 5.) a child born to or newly adopted by Qualified Beneficiaries who are not Covered Employees; 6.) a person who has enrolled as the dependent of a Qualified Beneficiary, but who is not a Qualified Beneficiary himself/herself; 7.) a Qualified Beneficiary who does not elect COBRA by the end of the COBRA election period; or 8.) a person who does not satisfy any other requirement necessary to be a Qualified Beneficiary.

Qualifying Event: Covered Employee

The following are Qualifying Events for Covered Employees:

1. A reduction in the number of hours worked by the Covered Employee for the employer including reduction due to strike, lockout, layoff, retirement or the employee going on active duty with the military.
2. The voluntary termination of employment from the employer by the Covered Employee.
3. Involuntary termination of the Covered Employee's employment from the employer for reasons other than the Covered Employee's gross misconduct as determined by the employer.

In the above circumstances, COBRA continuation coverage may continue for a maximum of 18 months from the date coverage would terminate under the Plan as a consequence of the Qualifying Event.

Qualifying Events: Covered Dependents

The following are Qualifying Events for Covered Dependents:

1. The death of the Covered Employee --up to 36 months of COBRA continuation coverage, if available, from the date coverage would terminate under the Plan.
2. Divorce or legal separation from a Covered Employee--up to 36 months of COBRA continuation coverage, if available, from the date coverage would terminate under the Plan. (Note: legal separation is not the same as the separation period that often precedes a divorce pursuant to some state laws. Merely living apart from a spouse during the pendency of a divorce action is not a Qualifying Event for purposes of COBRA.)
3. Termination of the Covered Employee's employment (for reasons other than gross misconduct as determined by the employer) or a reduction in the number of hours worked by the Covered Employee for the employer resulting in a Loss of Coverage under the Plan (including termination of employment or a reduction in the number of hours worked due to strike, lockout, layoff, retirement or the employee going on active duty with the U.S. Military), --up to 18 months of COBRA continuation coverage, if available, from the date coverage would terminate under the Plan. (NOTE: If the employer determines that the termination of employment was for "gross misconduct" then COBRA continuation coverage is also not available to any Covered Dependents who might have otherwise been eligible for COBRA continuation coverage due to the Qualifying Event.)
4. The Covered Employee's entitlement to Medicare, on or before the effective date of the Covered Employee's COBRA election -- the longer of 36 months from the earlier date of, the Medicare entitlement or 18 months from the Covered Employee's termination of employment or reduction in hours of employment.

CONTINUATION OF COVERAGE (COBRA)

5. A Covered Dependent child ceases to meet the eligibility requirements of the Plan --up to 36 months of COBRA continuation coverage, if available, from the date coverage would terminate under the Plan.

Except as noted above, generally the length of coverage is determined from the date coverage would be terminated under the Plan as a consequence of the Qualifying Event.

Note: If coverage is reduced or eliminated in anticipation of an event (for example, an employee terminating the coverage of the employee's spouse in anticipation of a divorce or legal separation), the reduction or elimination of coverage is disregarded in determining whether the event causes a Loss of Coverage.

Qualifying Event: Retirees and Covered Dependents of Retirees

The following is a Qualifying Event for Retirees or Covered Dependents of Retirees:

The filing of Chapter XI Bankruptcy by the employer, if coverage under the Plan is substantially eliminated within one year before or after the bankruptcy filing. This applies to: 1.) a Covered Employee who is a Retiree; and, 2.) a Covered Dependent who is a spouse, including the surviving spouse of a deceased Covered Employee who was a Retiree; and, 3.) a Covered Dependent child of a Covered Employee who is a Retiree.

In the case of a Covered Employee who is a Retiree or an individual who is the covered surviving spouse of a Covered Employee who was a Retiree on the day before the filing of a Chapter XI bankruptcy proceeding by the employer, coverage may continue until death. In the case of the Covered Dependent Spouse or Covered Dependent child of a Covered Employee who is a Retiree, coverage may continue for 36 months after the date of death of the Covered Employee who was a Retiree.

Qualifying Event: FMLA

If an employee does not return to work at the end of the employee's leave under the Family and Medical Leave Act or states that he/she will not be returning at the end of the leave period and the employee was covered under the Plan on the day before the first day of the leave or became covered during the leave, the employee will, on the first day after the end of his/her leave of notice of intention not to return to employment (as appropriate), be deemed to have experienced a "Qualifying Event" for purposes of COBRA continuation coverage if in the absence of COBRA continuation coverage the employee would lose coverage under the Plan before the end of the maximum coverage period. A Qualifying event will not occur if coverage is eliminated under the Plan on or before the last day of the Employee's leave for the class of employees (while continuing to employ that class of employees) to which the employee would have belonged if the employee had not taken leave.

Disability Extension

A Qualified Beneficiary may become entitled to a disability extension (additional 11 months in addition to an 18 month period of COBRA continuation coverage) if the requirements of paragraphs (1), (2), and (3) below are satisfied with respect to the Qualified Beneficiary. If the disability extension applies with respect to a Qualifying Event, it applies with respect to each Qualified Beneficiary entitled to COBRA continuation coverage because of that Qualifying Event.

1. The Qualifying Event that has occurred is a termination, or reduction of hours, of a Covered Employee's employment.

CONTINUATION OF COVERAGE (COBRA)

2. An individual (whether or not the Covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event described in paragraph (1) above is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. For this purpose, the period of the first 60 days of COBRA continuation coverage is generally measured from the date of the Qualifying Event described in paragraph (1) above. However, in the case of a Qualified Beneficiary who is a child born to or placed for adoption with a Covered Employee during a period of COBRA continuation coverage, the period of the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. For purposes of this paragraph (2), an individual is determined to be disabled within the first 60 days of COBRA continuation coverage if the individual has been determined under Title II or XVI of the Social Security Act to have been disabled before the first day of COBRA continuation coverage and has not been determined to be no longer disabled at any time between the date of that disability determination and the first day of COBRA continuation coverage.
3. Any of the Qualified Beneficiaries affected by the Qualifying Event described in paragraph (1) above must provide a copy of the Social Security Administration Disability Determination letter to the Plan Administrator on a date that is both within 60 days after the date the determination is issued and before the end of the original 18 month maximum coverage period that applies to the Qualifying Event.

Election of Coverage

Each dependent who is a Qualified Beneficiary has an independent right of election under the Plan. If either the Covered Employee or the Qualified Beneficiary who is the spouse of a Covered Employee makes an election for COBRA continuation coverage but does not specify whether the election is for single or other coverage, then the election will be deemed to cover all eligible Qualified Beneficiaries. The election of COBRA continuation coverage on behalf of the Covered Dependent child who is a minor can be made by the parent or legal guardian.

If the Qualified Beneficiary is totally incapacitated and is not legally competent to make an election for COBRA continuation coverage, the 60 day election period is tolled until such time as the Qualified Beneficiary is able to make an election or a guardian or legal representative is appointed who is able to make the election on behalf of the Qualified Beneficiary.

In general, a Qualified Beneficiary is only entitled to elect the same type of coverage in effect immediately before the Qualifying Event. However, a Qualified Beneficiary has the same right to change from family to single coverage.

A Qualified Beneficiary is entitled to the same coverage that is available to other similarly situated non-COBRA beneficiaries covered under the Plan. However, COBRA continuation coverage is subject to the Qualified Beneficiary's eligibility for coverage. The Plan Administrator reserves the right to terminate a Qualified Beneficiary's COBRA continuation coverage retroactively if the Qualified Beneficiary is determined to be ineligible.

If coverage under the Plan is modified for non-COBRA Beneficiaries the coverage under the Plan will be modified in the same manner for all Qualified Beneficiaries covered under the Plan.

COBRA continuation coverage commences on the day of the Qualifying Event if COBRA continuation coverage is properly elected and the applicable premium is paid as specified herein.

CONTINUATION OF COVERAGE (COBRA)

However, if a Qualified Beneficiary initially elects not to continue coverage under COBRA, the Qualified Beneficiary may revoke that non-election of COBRA continuation coverage at any time during the 60 day election period. The Plan, however, will only provide COBRA continuation coverage beginning with the date of the revocation of the non-election and not retroactively to the date of the actual Qualifying Event. This will result in a lapse of continuous coverage under the Plan. Qualified Beneficiaries must provide notice of the election of COBRA continuation coverage in writing.

If COBRA Continuation Coverage is rejected in favor of alternate coverage under the Plan, COBRA Continuation Coverage will not be offered at the end of that period. If alternate coverage is offered, the COBRA Continuation Coverage period will be reduced to the extent such coverage satisfies the requirement of COBRA. Alternate Coverage may include, for example, continuation by USERRA or any other Plan provision or retiree coverage.

Responsibility to Provide Notice to the Plan Administrator

The employee or a family member has the responsibility to inform the Plan Administrator of a divorce or legal separation of a Covered Employee, or of a Covered Dependent losing eligibility under the Plan within 60 days of: 1.) the date of the event ; or, 2.) the date on which coverage would end under the Plan because of the event, whichever is the later to occur. If written notice is not received within that 60 day period, the Covered Dependent will not be entitled to elect COBRA continuation coverage. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, reduction in the number of hours worked or Medicare entitlement.

When the Plan Administrator is notified that a Qualifying Event has occurred, the Plan Administrator will inform the Qualified Beneficiary that he or she has the right to elect COBRA continuation coverage. The Qualified Beneficiary has 60 days to decide whether or not to elect the COBRA continuation coverage. The 60 day period runs from whichever is the later: the date the notice is given, or the date coverage terminates under the Plan.

Duration of COBRA Continuation Coverage

If the Qualified Beneficiary does not elect COBRA continuation coverage, coverage under the Plan will terminate. If the Qualified Beneficiary elects COBRA continuation coverage, coverage will continue for either 18, 29 or 36 months, depending on the Qualifying Event that caused the Loss of Coverage. However, see the Termination of COBRA Continuation Coverage section below.

If during a COBRA continuation coverage period of only 18 months or if during a COBRA continuation coverage period of 29 months another Qualifying Event takes place that would entitle a Covered Dependent spouse or child who is a Qualified Beneficiary to COBRA continuation coverage, coverage may be extended for that Covered Dependent spouse or child, but **COBRA continuation coverage will in no event exceed 36 months from the date of the initial Qualifying Event.** (Note: additional coverage may be available for Covered Employees who are Retirees and their Covered Dependents.) This COBRA continuation coverage would not be available to a spouse or other dependent who is not a Qualified Beneficiary and who became covered after COBRA continuation coverage became effective. The events which qualify as a second Qualifying Event are death of the Covered Employee, divorce or legal separation from the Covered Employee, a Covered Dependent child ceasing to qualify as a Dependent under the Plan, or Medicare entitlement of the Covered Employee. The Qualified

CONTINUATION OF COVERAGE (COBRA)

Beneficiary must notify the Plan Administrator within 60 days of a second Qualifying Event where such event is the divorce, legal separation or loss of dependent status of the Qualified Beneficiary.

Termination of employment following a reduction in hours with the employer does not constitute a second Qualifying Event. In this event, the COBRA Qualified Beneficiaries would be entitled only to 18 months of COBRA continuation coverage measured from the earlier Qualifying Event as a result of a reduction in hours.

Termination of COBRA Continuation Coverage

COBRA continuation coverage will be terminated prior to the 18, 29 or 36 month period for the following reasons:

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for COBRA continuation coverage is not paid by the Qualified Beneficiary on a timely basis or within any applicable grace period.
3. The Qualified Beneficiary becomes covered under another group health plan or entitled to Medicare (either Medicare Part A or Part B, whichever comes first) after the date of the Qualified Beneficiary's election, even if that coverage is different than coverage currently in place. If the Qualified Beneficiary has a condition which is not covered under the other group health plan because the other group health plan contains a pre-existing condition limitation, then the Qualified Beneficiary may continue COBRA continuation coverage under the Plan for the period of time which he or she is denied coverage under the other group health plan for the pre-existing condition, but no longer than the COBRA continuation coverage period for which the Qualified Beneficiary is eligible. (Coverage under the Plan will not be permitted if the other group health plan contains a pre-existing condition exclusion or limitation which does not apply to the Qualified Beneficiary by reason of the other group health plan's portability, access and renewability provision restricting the application of the pre-existing condition limitation.)
4. The Plan terminates coverage on the same basis that the Plan terminates coverage of similarly situated non-COBRA Qualified Beneficiaries.
5. For a Qualified Beneficiary who has continued COBRA continuation coverage due to Social Security Administration Disability status as a Covered Employee or as a Covered Dependent of a Covered Employee, the date on which the Qualified Beneficiary is no longer considered to be disabled by the Social Security Administration. However, such a determination does not allow termination of the COBRA continuation coverage of a Qualified Beneficiary before the end of the maximum coverage period that would apply without regard to the disability extension. In this case the Qualified Beneficiary must notify the Plan Administrator within 30 days of the Social Security Administration's determination that the Qualified Beneficiary is no longer disabled. COBRA continuation coverage will be terminated on the first day of the month following 30 days after the date of the Social Security Administration's determination.
6. The Qualified Beneficiary is determined to have been ineligible for coverage under the Plan or is determined not to be a Qualified Beneficiary.

Payment of Premium

The Plan may require payment of a premium for COBRA continuation coverage. The premium will not exceed 102% of the applicable premium for the period in question except for the 11 months of a disability extension. If the disabled Qualified Beneficiary is qualified for and elects the disability extension, a premium not to exceed 150% of the applicable premium may be charged. If only the non-disabled family members of the disabled Qualified Beneficiary elect the disability extension, then they will be charged a premium not to exceed 102% of the applicable premium. In addition, the premium payment for the first 30 days for an employee who is eligible for coverage under the Uniformed Services Employment and Re-employment Rights Act of 1994 must be the same as for an active employee. Thereafter, the premium amount will not exceed 102% of the applicable premium for the remaining 17 months.

Determination of the applicable premium will be made in advance and will apply for a period of 12 months, the date being established by the employer, unless: 1.) The Plan has previously charged less than the maximum amount it is permitted to charge and the increased amount does not exceed the maximum amount permitted to be charged; or 2.) The increase occurs during the disability extension and the increased amount to be paid does not exceed the maximum amount permitted to be charged; or 3.) A Qualified Beneficiary changes the coverage being received.

The premium will be based in part, on a reasonable estimate of the cost of providing coverage for the period for similarly situated active employees or on the basis of past costs of providing such coverage.

The employer must allow the Qualified Beneficiary or a third party to pay for such COBRA continuation coverage on a monthly basis. The Qualified Beneficiary has 45 days from the date on which the Qualified Beneficiary makes a written election of COBRA continuation coverage to pay for the first month's premium. The initial premium payment must include all past amounts to the date of election and shall apply to the period of COBRA continuation coverage beginning immediately after the coverage under the Plan terminates except for cases where the Qualified Beneficiary does not elect to continue coverage and then revokes that non-election.

The Plan is not required to pay for any claims incurred prior to a timely election of COBRA continuation coverage and proper premium payment for such COBRA continuation coverage, however, such claims shall be eligible for payment upon timely election of such COBRA continuation coverage and proper premium payment for the COBRA continuation coverage.

After the first month's COBRA continuation coverage under COBRA, the Qualified Beneficiary has a 30 day grace period from the first day of the coverage period in which to make payment. The employer or Plan Administrator will not send a bill each month. The Qualified Beneficiary or designated representative, is required to remit payment of the applicable premium to the employer or to the address specified in the COBRA notice on the date established by the employer. If payment is not received within the amount of time specified by the employer, and after the grace period has expired, COBRA continuation coverage will terminate.

If payment is made by check and that check is returned to the employer by the bank on which such payment is drawn for Non-Sufficient Funds, the Qualified Beneficiary has until the end of the applicable grace period to properly fund this payment. A check returned to the employer for any reason that is not funded prior to the end of the grace period will not be considered to be a timely payment of the applicable premium and COBRA continuation coverage under the Plan will terminate.

CONTINUATION OF COVERAGE (COBRA)

For purposes of COBRA, all benefits provided by this Plan shall be deemed to be one, single plan. (Short Term Disability and Long Term Disability benefits, if any, shall not be deemed a part of this Plan).

DENTAL BENEFITS

Eligible charges are covered as specified on the Schedule of Benefits. Eligible charges are subject to the Usual and Customary fee for that type of service. All limitations and exclusions of the Plan apply.

Pre-certification of Benefits

Prior to the beginning of extensive dental treatment of \$250 or more, the dentist should submit to D. Edward Wright, Inc. a pre-treatment estimate stating the proposed services and fees. D. Edward Wright, Inc. will then pre-certify the eligible benefits for each dental service. You and your dentist will be given a copy of the pre-treatment estimate which certifies the services covered and the benefits available. **The pre-treatment estimate is not a guarantee of benefits.** Charges are subject to all Plan provisions. Any ineligible services or fees would be the responsibility of the covered person. The covered person would have the final decision regarding the dental treatment.

If the Pre-certification of Benefits process is not followed, benefits will be determined by D. Edward Wright, Inc., taking into account alternate methods of treatment for the dental condition, based upon acceptable standards of dental practice and all Plan provisions.

Class I - Preventive Services

1. routine oral examinations, but not more than once in six consecutive months;
2. routine prophylaxis (cleaning and scaling) by a dentist or a dental hygienist, but not more than once in six consecutive months;
3. space maintainers for dependents younger than age 16;
4. sealants for posterior permanent teeth up to age 14 and not more than one time per tooth while covered under the Plan;
5. emergency palliative treatment;
6. oral examinations necessitated by an accidental injury, except when covered by a medical plan;
7. topical application of fluoride by a dentist or dental hygienist for dependents younger than 19 years of age, limited to one application in twelve consecutive months; and
8. dental x-rays including full mouth (once in 5 consecutive years), bitewings (once in six consecutive months) and other x-rays needed to diagnose a condition.

Class II - Basic Services

1. amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth;
2. dental x-rays not included in Preventative Services;
3. extraction of teeth (includes local anesthesia and routine post operative care);

DENTAL BENEFITS

4. consultations and examinations by a dentist, other than for routine or orthodontic purposes;
5. antibiotic drugs;
6. anesthesia or analgesia rendered in connection with a covered service, except when covered by a medical plan;
7. oral surgery: oral surgery is limited to the removal of teeth, preparation of the mouth for dentures and removal of tooth generated cysts of less than ¼ inch;
8. recementing bridges, crowns, or inlays;
9. treatment of periodontal and other diseases of the gums and tissues of the mouth; and
10. endodontics, including pupal therapy and root canal therapy.

Class III - Major Services

1. gold restorations including inlays, onlays, foil fillings, and crowns to restore diseased or accidentally broken teeth. The cost of gold restorations in excess of the cost of amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold. These procedures are covered when the tooth has been damaged by extensive dental caries or fractures and cannot be restored with a filling restoration;
2. installation of precision attachments for removable dentures;
3. replacement of inlays, onlays and crowns but not more than once in five consecutive years;
4. initial placement of fixed bridges including inlays, onlays and crowns used as abutments to the bridge;
5. repair of crowns, bridgework, and removable dentures;
6. addition of clasp or rest to existing partial removal dentures;
7. initial placement of partial or full dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit, including repairs and adjustments incurred within six months following the initial placement, provided:
 - if a cast chrome or acrylic denture will restore the dental arch satisfactorily, payment will not be made toward a more elaborate or precision appliance. Any balance will be the responsibility of the covered person; or
 - if a personalized restoration or specialized technique is chosen, payment will not be made for more than the cost of the standard service. Any balance will be the responsibility of the covered person;
8. replacement of an existing partial, full denture or fixed bridge, or addition of teeth to an existing partial or fixed bridge, but only if satisfactory evidence is presented that:
 - the replacement or addition of teeth is required to replace one or more teeth extracted after the existing partial or fixed bridge was placed;

DENTAL BENEFITS

- the existing denture or fixed bridge was placed at least five years prior to its replacement and the existing denture or fixed bridge cannot be made serviceable; or
 - the existing replacement is an immediate temporary and replacement by a permanent partial denture, full denture or bridge work occurs within twelve months from the date of initial placement of the immediate temporary replacement; and
9. relining or rebasing dentures more than six months after placement, or replacement of the lining or base once in 36 consecutive months.

Class IV - Orthodontia Services

Orthodontics are limited to covered dependent children under the age of 19. Orthodontia services are those rendered for the treatment of dental irregularities which result in appliance therapy to reposition teeth and to establish normal occlusion.

Payment for eligible charges shall be made monthly commencing at the beginning of the treatment and thereafter in equal amounts calculated on the basis of the total cost and duration of the treatment plan, regardless of when services are rendered during any such month that the treatment plan is in effect. This method of payment is applied to any portion of the treatment plan that is completed while the treatment plan is in effect.

If orthodontic treatment is terminated for any reason before completion, benefits shall cease with payment to the date of termination. If such services are resumed, benefits, to the extent remaining, shall resume.

Treatment may be terminated by the dentist for lack of the covered person's interest and cooperation. If termination occurs, the dentist should make written notification to D. Edward Wright, Inc. and to the covered person.

Related orthodontic services such as examinations, extractions and x-rays are covered at the orthodontic coinsurance amount and up to the Orthodontia Plan Maximum.

The Plan will not cover the repair or replacement of an orthodontic appliance.

Extension of Dental Benefits

No benefits shall be paid after coverage terminates except as indicated below, provided the treatment is completed within 31 days after the coverage under this Plan ends:

- An appliance or change of appliance (excluding active or passive orthodontic appliances), if the master impression has been made prior to termination;
- A crown, bridge or cast restoration, if the tooth or teeth have been prepared prior to termination; and
- Root Canal therapy, if the pulp chamber has been opened prior to termination.

LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN

The following charges are not covered. No charges will be covered with respect to them, except as specified:

1. charges arising out of, or in the course of, any occupation or employment for wage or profit, or for which the covered person is entitled to benefits under any Workers' Compensation, occupational disease law or similar laws, regardless of whether such policies are in force and regardless of whether benefits are claimed or not;
2. charges for a hospital confinement, medical or surgical services, or other treatment furnished or covered by, or on behalf of, the United States, or any state, province, or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance;
3. charges which are determined by D. Edward Wright, Inc. to be cosmetic in nature including the alteration or extraction and replacement of sound natural teeth to change appearance;
4. charges for services and supplies for prosthodontics including crowns, dentures and fixed bridges which were started prior to the date the covered person became eligible under this Plan or which were rendered after the termination date of coverage, unless otherwise specified by the Plan;
5. premedications, prescription drugs, general anesthesia for restorative dentistry unless medically necessary, services of an anesthesiologist, charges for hospitalization, charges for failure to keep a scheduled appointment, charges for the completion of reports, or charges for the completion of claim forms;
6. charges which are not medically necessary;
7. appliances or treatments for altering vertical dimension, for restoring or maintaining occlusion, for replacing tooth structure lost by abrasion or attrition, for correcting congenital or developmental malformations or for aesthetic purposes;
8. charges for bite registration or bit analysis;
9. charges for treatment performed by any person other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist in accordance with generally accepted dental standards;
10. charges incurred due to an illness or injury which results from war, declared or undeclared, and/or armed aggression by the military forces of any country or combination of countries or any act incident to war;
11. replacement of lost or stolen dentures, or charges for duplicate dentures, bridgework or appliances;
12. any service which is not specifically provided for by this Plan;

LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN

13. periodontal splinting procedures, other than provisional intracornal stabilization of mobile teeth;
14. precision attachments, precision partials and treatment partials, unless otherwise specified by the Plan;
15. services received from a dental or medical department, maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar persons or groups;
16. dental treatment of an injury resulting from the commission of, or attempt to commit by the covered person, a felony or aggravated battery, unless the injury results from an act of domestic violence or medical condition (which includes both a physical condition and/or a mental health condition);
17. charges which are reimbursable through medical coverage provided by or available through any applicable "No-Fault" automobile law or coverage, or any other automobile, homeowners, aircraft, boat owners, or similar policy of insurance;
18. charges for myofunctional therapy, athletic mouth guards or night guards;
19. charges covered under the medical portion of the Plan;
20. services rendered by a family member or relative of the covered person unless satisfactory evidence of payment is provided;
21. charges for porcelain crowns or pontics placed on or replacing teeth in back of the second bicuspid;
22. charges for pulp vitality tests will only be covered when rendered with other procedures;
23. charges for acid etch will only be covered if it is an integral part of the placement of a composite restoration;
24. if the covered person changes dentists during a treatment program, the benefits provided will be the same as if only one dentist had completed the program;
25. services or supplies which are Experimental or Investigational;
26. charges for behavioral management;
27. charges for personal supplies or equipment such as water piks, toothbrushes, or floss holders;
28. dietary counseling, oral hygiene, dietary instruction, or plaque control;
29. transplanting teeth or implanting fabricated teeth;
30. charges in excess of the "Usual and Customary," as specified in the General Terms and Definitions and General Information sections of the Plan;
31. charges incurred which the covered person is not, in the absence of this Plan, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this Plan;
32. not a covered expense under the Plan;

LIMITATIONS AND EXCLUSIONS OF THE DENTAL PLAN

- 33.** charges for services not provided by a Physician/Provider are not covered under the Plan;
- 30.** a response for information may be required by the Plan in order to process claims. The Plan has the right to deny claims submitted for benefit payment if such information is not received. (Please contact the Third Party Administrator if you have questions regarding the required information);
- 31.** benefits under this Plan are limited to co-payments and/or deductibles not covered under an HMO, including eligible charges that are specifically excluded under the HMO. There will be no coverage under this Plan for any service, treatment or supply not covered by the HMO because the covered person chose to obtain such service, treatment or supply from a provider who is not an HMO participating provider, or because the covered person did not obtain a referral from the covered person's primary care physician, if such referral is required by the HMO; or
- 32.** charges for sealants, unless otherwise specified by the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits section is intended to determine which plan provides benefits when there are two or more plans providing coverage to an individual.

Definitions

For purposes of this Coordination of Benefits section, “Plan” means any plan providing medical or dental benefits or services by a: (a) group, blanket, or franchise insurance coverage; (b) group practice, and other group prepayment coverage; (c) any coverage under labor-management trusted plans, union welfare plans, employer organization plans, or employee benefit organization plans; (d) any coverage under governmental programs such as, but not limited to, Medicare, and any coverage required or provided by any Statute; (e) individual automobile “no-fault” and traditional auto insurance; (f) individual or family insurance; (g) subscriber contracts; (h) individual or family coverage through Health Maintenance Organizations (HMO); (i) limited service organizations or any other prepayment; (j) student accident insurance provided through or by an educational institution; (k) group practice or individual practice plan; and (l) this Plan.

The term “Plan” is construed separately with respect to each Plan, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such Plan, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

“**Allowable Expense**” means any Usual and Customary fee, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

“**Claim Determination Period**” means calendar year, except that if in any calendar year the person is not covered under the Plan for the full calendar year, the Claim Determination Period for that year will be that portion during which the person was covered under the Plan.

“**Claim**” means a request that benefits of a Plan be provided or paid.

“**Primary Plan**” means a Plan whose benefits are determined without regard to any other Plan.

“**Secondary Plan**” means a plan which is not a primary Plan according to the Order of Benefit Determination rules, and whose benefits are determined after those of another Plan and may be reduced because of the other Plan's benefits.

For purposes of this Coordination of Benefits section, “This Plan” means the **HR America, Inc.** Dental Plan.

Effect on Benefits

Maintenance of Benefits: when a claim is made, the Primary Plan pays its benefits without regard to any other Plan. The Secondary Plan adjusts its benefits so that the total benefits available do not exceed the Allowable Expense. No Plan pays more than it would without the coordinating provision. This Plan will not administer the Coordination of Benefits with a reserve amount.

Order of Benefits Determination

The rules establishing the Order of Benefits Determination are:

1. If the other Plan does not have Coordination of Benefits, that Plan pays first.
2. The benefits of a Plan which covers the person as an employee, member, or subscriber (other than as a dependent) are determined before the benefits of a Plan which covers the person as a dependent.
3. **Birthday Rule:** the benefits of a Plan which covers the person as a dependent are determined according to which parent's birthdate occurs first in a calendar year (day and month). If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined first. If the other Plan does not contain the birthday rule but has a rule which coordinates benefits based on gender and the Plans do not agree on the Order of Benefits, the rule in the other Plan will determine the Order of Benefits.

If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the dependent are determined in this order:

- when parents are separated or divorced and the parent with physical custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody will be the Primary Plan;
 - when parents are divorced and the parent with physical custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody are determined before the benefits of the Plan which covers that child as a dependent of the stepparent. In addition, the benefits of a Plan which covers that child as a dependent of the stepparent are determined before the benefits of a Plan which covers that child as a dependent of the parent without custody; and
 - notwithstanding the provisions of the above, if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility are determined before the benefits of any other Plan which covers the child as a dependent child.
4. When rules 1., 2., and 3. do not establish an Order of Benefits Determination, the benefits of a Plan which covers the person as a laid-off or retired employee, or as a dependent of such person, are determined after the benefits of a Plan which covers

COORDINATION OF BENEFITS

such person through his or her own present employment or through the present employment of another person.

5. When rules 1., 2., 3., and 4. do not establish an Order of Benefits Determination, the benefits of a Plan which has covered the person for the longer period of time are determined before the benefits of a Plan which has covered such person the shorter period of time.

Right To Necessary Information

This Plan may require or may need to disclose certain information in order to apply and coordinate these provisions with other plans. To secure the needed information, this Plan, without the covered person's consent, will release to, or obtain from, any insurance company, organization or person, information needed to implement this provision. The covered person shall agree to furnish any information required to apply these provisions.

Coordination of Benefits With Medicare

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations. If the covered person is eligible for Medicare Benefits, but not necessarily enrolled, the benefits under this Plan will be coordinated to the extent benefits would have been payable under Medicare, as allowed by Federal Statutes and Regulations.

Facility of Payment

Payment made under any other Plan which, according to these provisions, should have been made by this Plan, will be adjusted. This Plan may pay to the organization which made a payment the amount which is determined to be warranted. Any amount paid is deemed to be a benefit paid under this Plan.

HOW TO FILE A CLAIM

The employee and covered spouse will receive a D. Edward Wright, Inc. identification card. It will show the employee's name, group name and group number. The provider of service should bill D. Edward Wright, Inc. directly or the covered person may submit an itemized claim for services to D. Edward Wright, Inc. A separate itemized claim must be sent for each family member for which benefits are being claimed. Itemized claims should be sent to the address specified on the Group Benefits identification card.

The covered person may choose any provider of service. There is no restriction on the selection of a provider as long as the provider of service meets the definitions contained in the Plan. Benefits are payable directly to the provider of service and only to the employee if proof of full payment is submitted. If D. Edward Wright, Inc. needs more information to process a claim, the covered person or the provider of service will be contacted. When filing a claim, the covered person must submit proof of each charge by way of an "itemized claim" from the provider of service. An "itemized claim" is one which shows:

1. Employee's name, address and Social Security number.
2. Dependent's name, if the claim is on a dependent.
3. Employer's name.
4. Name and address of the provider of service.
5. Diagnosis.
6. Itemization of charges.
7. Date the illness or injury began or the date treatment started.
8. Prescription drug bills (not cash register receipts) showing RX number and the name of the drug.

Canceled checks, cash register receipts or personally prepared claims are not accepted in lieu of itemized claims from providers of service.

If benefits are subject to the Coordination of Benefits provision, whereby another plan is required to pay benefits first, a copy of the other plan's Explanation of Benefits should be sent to D. Edward Wright, Inc. This can be done either when initially submitting the claim or as soon as possible thereafter. This procedure will expedite the processing of claims subject to the Coordination of Benefits provision.

GENERAL TERMS AND DEFINITIONS

“ACTIVELY AT WORK” means that the employee is at work and performing the regular duties of the employee's position for the employer.

An employee is considered to be actively at work for the employer on: (a) each day of regular paid vacation; (b) each regular non-working day, provided in each instance that the employee was actively at work on the last regular work day preceding the absence; (c) any day an employee is covered under the Plan by virtue of a leave as described in the Plan (other than an FMLA leave); (d) any day an employee is on an FMLA leave; or (e) for purposes of the waiting period to obtain coverage under the Plan as specified in the “Effective Date of Coverage” provision in the Effective Date of Coverage section of the Plan, any day on which an employee is absent from employment with the employer due to a health factor of the employee.

“CALENDAR YEAR” means the period from January 1 through December 31 of the same year.

“COVERED PERSON” means a person meeting the eligibility requirements for coverage as specified in the Plan, who has satisfied any applicable waiting period and who is properly enrolled in the Plan.

"CREDITABLE COVERAGE" means coverage of the covered person under a group health plan as defined in the Federal Register Vol. 62, No. 67, health insurance coverage, Part A or Part B of Title XVIII of the Social Security Act, Title XIX of the Social Security Act (other than coverage consisting of benefits solely under section 1928), Chapter 55 of Title 10, United States Code, a medical care program of the Indian Health Service or of a tribal organization, a state health benefits risk pool as defined in the Federal Register Vol. 62, No. 67, a health plan offered under Chapter 89 of Title 5, United States Code, a public health plan, or a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)). Creditable Coverage does not include coverage consisting solely of excepted benefits as defined in the Federal Register Vol. 62, No. 67.

“DEPENDENT” means:

1. a lawful spouse of the employee;
2. each unmarried Child (as defined in subparagraphs a-e below) of the covered employee who is less than age 19 or who is at least age 19 but less than age 24 and meets the requirements of the “Full-time Student” provision as specified in the Eligibility for Coverage section of the Plan. Unless otherwise required by court order or divorce decree, the covered employee must provide financial support and maintenance to the child as defined by the United States Internal Revenue Code and each child must qualify as a dependent by that definition in the current year or on the most recently filed Federal Income Tax Return. “Child” shall mean:

GENERAL TERMS AND DEFINITIONS

- (a) a natural born son or daughter of the covered employee;
- (b) a child for whom the covered employee has been appointed guardian by court order or a stepchild, provided the employee meets the support and maintenance requirements for the stepchild or ward as specified above and provided the stepchild or ward has not attained the limiting age requirements as specified above;
- (c) a child who meets the requirements of the Handicapped Child provision as specified in the Eligibility for Coverage section of the Plan;
- (d) a child who meets the requirements of the Adopted Child provision as specified in the Eligibility for Coverage section of the Plan; or
- (e) a child who meets the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order as specified in the Eligibility for Coverage section of the Plan.

“EFFECTIVE DATE OF COVERAGE” means the date on which coverage under the Plan begins for a covered person, provided application for coverage was made when eligible for coverage under the Plan.

“EFFECTIVE DATE OF THE PLAN” means August 1, 2003

“EMPLOYEE” means a full-time employee actively at work and working 30 or more hours per week, 48 weeks per year on a regular basis for the employer.

An employee, for purposes of this Plan shall not include a temporary, part-time, seasonal, independent contractor, leased (even if determined to be a common-law employee) or a retired employee as such classifications are determined by the employer in its sole discretion and/or as such classification may be reflected on the payroll records of the employer. Any classification, reclassification or other characterization of any such individual as an employee of the employer, whether as a statutory, common law employee or otherwise, by a court of law or by action of any federal, state or local governmental agency shall be of no affect on the exclusion of such individual from participation in the Plan. Any individual whom the Plan Administrator determines is not an employee shall not be treated as an employee hereunder solely because he has been classified or reclassified as an employee of the employer by any court or government agency.

“EMPLOYER” means **HR America, Inc.**

“EXPERIMENTAL OR INVESTIGATIONAL” means any treatments, procedures, devices, drugs or medicines for which one or more of the following is true:

1. the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;

GENERAL TERMS AND DEFINITIONS

2. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II, or III clinical trial(s) or under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis;
3. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

Experimental or Investigational shall also mean: (a) any treatments, services or supplies that are educational or provided primarily for research; or (b) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of non-human organs, tissues, or cells.

“FAMILY MEMBER” means a covered person's spouse, child, parent, brother, sister and any other eligible dependent as described by the Plan.

“ILLNESS” means pregnancy or a disease or disturbance in the function or structure of the body which causes physical signs and/or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or systems of the body.

“INJURY” means a condition caused by accidental means and from an external force which results in damage to the covered person's body from an external force.

“LATE ENROLLEE” means an individual who enrolls for coverage under the Plan other than during:

1. the first period in which the individual is eligible to enroll under the Plan, or
2. a special enrollment period. [See "Special Enrollment Provisions" in the Effective Date of Coverage section of the Plan.]

“MASTER PLAN DOCUMENT” means that document signed by the Plan Sponsor and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto which set forth the terms of the Plan.

“MAXIMUM BENEFIT” means the total eligible charges that the Plan will pay per covered person while that covered person is covered by the Plan.

“MEDICALLY NECESSARY” means that a service, treatment, procedure, equipment, drug, device or supply provided by a hospital, physician or other health care provider is required to diagnose or treat a covered person's illness or injury and which is, as determined by the Plan

GENERAL TERMS AND DEFINITIONS

Administrator: (1) consistent with the symptoms or diagnosis and treatment of the covered person's illness or injury; (2) appropriate under the standards of acceptable medical practice to treat that illness or injury; (3) not solely for the convenience of the covered person, physician, hospital or other health care provider; and (4) the most appropriate service, treatment, procedure, equipment, drug, device or supply which can be safely provided to the covered person and accomplishes the desired end result in the most economical manner. However, the fact that a provider may prescribe, order, recommend or approve a treatment, service or supply does not, of itself, make that treatment, service or supply medically necessary.

“MEDICARE” means the program for health benefits under Title XVIII of the Social Security Act as amended.

“PLAN” means this employer's Master Plan Document and all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto.

“PLAN ADMINISTRATOR” means **HR America, Inc.**

“PLAN SPONSOR” means **HR America, Inc.**

“PLAN YEAR” means the period beginning January 1 and ending December 31.

“SERVICE IN THE UNIFORMED SERVICES” means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

“THIRD PARTY ADMINISTRATOR” means **D. Edward Wright, Inc.**

“UNIFORMED SERVICES” means the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in the time of war or emergency.

“USUAL AND CUSTOMARY” means the fee usually and customarily accepted as payment for the same services within a geographical area in which the physician practices as determined by the Third Party Administrator.

In the case of a PPO Provider, Usual and Customary is the negotiated PPO discount rate for the service or procedure.

“WAITING PERIOD” means the period of time that must pass before an individual is eligible to be covered for benefits under the provisions of the Plan.

GENERAL INFORMATION

Administration of the Plan

The Plan Administrator administers the Plan. The Plan Administrator has retained the services of D. Edward Wright, Inc. as Third Party Administrator. The Plan is a legal entity and legal service of process directed to the Plan may be filed with the company identified in the Plan Information section as the Agent for Service of Legal Process. The employer may delegate any of its powers or responsibilities among its employees and to such other agents as the employer deems appropriate.

Benefit Claim Procedures and Appeal Procedures for Claims

Claims for benefits under the Plan should be directed to D. Edward Wright, Inc. at the address listed below.

Appeals (other than appeals of Urgent Care claim determinations) must be made in writing to the attention of the "Appeal Department" at the address listed below.

Urgent Care claims and appeals of Urgent Care claim determinations can be made in writing to the address listed below or, during D. Edward Wright, Inc.'s normal business hours, by fax or telephone at the numbers listed below.

D. Edward Wright, Inc.
111 E. Ludwig Rd., Ste. 108
Fort Wayne, IN 46825-4217
1-877-755-4010 / 260-969-4010
Fax 260-969-4011

Procedures Upon Initial Filing of a Claim

The following procedures apply to an initial filing of a claim with the Plan:

Time Limits on Decisions: The time frame for processing the covered person's initial claim depends on the type of claim it is: urgent care, concurrent care, pre-service or post-service. The covered person's claim will be processed according to the highest priority category that applies to it.

- 1. Urgent Care Claims:** If a covered person's claim is an urgent care claim for which the Plan requires pre-certification, the Plan will notify the covered person as soon as possible, taking into account the medical exigencies. A determination will be sent to the covered person no later than 72 hours after the Plan's receipt of the covered person's claim.

If the covered person fails to provide sufficient information to allow the Plan to make its determination, the Plan will notify the covered person as soon as possible, but not later than 24 hours after the Plan receives the covered person's claim. The covered person will

GENERAL INFORMATION

have a reasonable period of time (not less than 48 hours) to respond and provide the additional information. After the Plan receives this additional information, the Plan will notify the covered person as soon as possible whether his or her benefit claim has been granted or denied. This notification will occur no later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information; or (2) the end of the period granting the covered person additional time to provide the additional information.

An urgent care claim is any claim for medical care or treatment where using the non-urgent care claim time-frames:

- a) Could seriously jeopardize the covered person's life or health or ability to regain maximum function; or
 - b) Would, in the opinion of a physician with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- 2. Concurrent Care Conditions:** If the covered person is currently receiving ongoing treatment or the treatment is going to be provided over a number of sessions, special rules apply:
- a) Any notice of reduction or termination (except by Plan amendment or termination) will be given to the covered person by the Plan at a time sufficiently in advance of the reduction or termination to allow the covered person to appeal and obtain a determination on review before the benefit is reduced or terminated.
 - b) Any request made by the covered person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, will be decided by the Plan as soon as possible taking into account medical exigencies. Notice to the covered person will be made within 24 hours after the Plan receives the request, as long as the Plan receives his or her claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- 3. Pre-Service Claim:** For a pre-service claim, the Plan will notify the covered person of the decision within a reasonable period of time appropriate to the medical circumstances. This notification will be made no later than 15 days after the Plan receives the covered person's claim.

The 15-day period may be extended for an additional 15 days if:

- a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and
- b) The Plan notifies the covered person, prior to the end of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

GENERAL INFORMATION

- c) If the 15-day extension is necessary because the covered person failed to submit the information necessary to decide the claim, the Plan will provide notice to the covered person of this 15-day extension and will describe the required information necessary to decide the claim. The covered person will have at least 45 days from receipt of this notice to provide the requested information.

A pre-service claim means any 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.

- 4. Post-Service Claim:** For a post-service claim, the Plan will notify the covered person of the decision within a reasonable period of time. This notification will be made not later than 30 days after receipt of the claim by the Plan.

The 30-day period may be extended for an additional 15 days if:

- a) The Plan determines that the extension is necessary due to matters beyond the control of the Plan; and
- b) The Plan notifies the covered person, prior to the end of the 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- c) If the 15-day extension is necessary because the covered person failed to submit the information necessary to decide the claim, the Plan will provide notice to the covered person of this 15-day extension and will describe the required information necessary to decide the claim. The covered person will have at least 45 days from receipt of this notice to provide the requested information.

A post-service claim is any claim under the Plan that does not satisfy the definitions of the other types of claims.

Failing to Follow the Plan's Procedures for Filing a Claim: If the covered person fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the covered person as soon as possible, but not later than five days after the failure (24 hours if the failure involved urgent care). This notification can be oral, unless the covered person requests that it be in writing.

Manner and Content of Notification of Benefit Determination

If the Plan denies the covered person's claim for benefits, the Plan will provide the covered person with a written or electronic notification of this determination.

Appeal of Adverse Benefit Determination

If the Plan issued an adverse benefit determination on a claim submitted by the covered person, the covered person has a right to appeal the adverse benefit determination to a named fiduciary of the Plan. This review will:

1. Provide the covered person with the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
2. Provide that the covered person will be provided, upon request and free of charge, reasonable access to, or any copies of, all documents, records and other information relevant to his or her claim for benefits;
3. Take into account all comments, documents, records and other information submitted by the covered person relevant to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
4. Provide that the covered person has at least 180 days following receipt of a notification of an adverse benefit determination to appeal the initial adverse determination and 90 days following receipt of the first appeal determination to request a final appeal;
5. Not afford deference to the initial adverse benefit determination and provide that the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
6. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, an appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
7. Identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the covered person's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
8. Provide that the health care professional who provides consulting services will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination nor the subordinate of any such individual;
9. Provide, in the case of a claim involving urgent care, for an expedited review process pursuant to which:
 - a) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the covered person; and

- b) All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the covered person by telephone, facsimile, or other available similarly expeditious method.

Timing of Notification of Benefit Determination on Review

If the covered person appeals an adverse benefit determination, the Plan will respond to his or her appeal within certain time limits:

1. **Urgent Care Claims.** In the case of a claim involving urgent care for which the Plan requires pre-certification, the Plan will notify the covered person of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the covered person's request for review of an adverse benefit determination.
2. **Pre-Service Claims.** For pre-service claims, the Plan will notify the covered person of the decision within a reasonable period of time appropriate to the medical circumstances. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 15 days after the Plan receives the covered person's request for review of an adverse benefit determination.
3. **Post-Service Claims.** For post-service claims, the Plan will notify the covered person of the decision within a reasonable period of time. Because the Plan provides for two appeals of an adverse benefit determination, such notification will be provided, with respect to any one of such two appeals, not later than 30 days after the Plan receives the covered person's request for review of an adverse benefit determination.

Manner and Content of Notification of Benefit Determination on Review

The Plan will provide the covered person with written or electronic notification of the Plan's benefit determination and review.

The Plan Sponsor will have the sole discretion to make the determination of all final appeals. First appeals will be determined by the Third Party Administrator or its designee. Benefits under the Plan will be paid only if the Plan Sponsor (or its designee) decides in its full and absolute discretion that the covered person is entitled to such benefits.

If any time limitation stated in this section is less than that required by law, the limitation is extended to agree with the minimum period permitted by law.

The Plan will not be liable for any benefits after the date the Plan has terminated.

If the Plan provides Short Term Disability Benefits, then please refer to the Short Term Disability Benefits section of the Plan for information regarding Short Term Disability Benefits claim appeal procedures.

Calculation of Plan Maximum Amounts

Amounts paid by the Plan shall be used in calculating any Plan Maximum amounts under the Plan.

Clerical Error

Clerical error on the part of the Plan Administrator or Third Party Administrator will not invalidate or extend coverage otherwise in force, nor continue coverage otherwise terminated. Upon the discovery of a clerical error, an equitable adjustment may be made as determined by the Third Party Administrator. The covered person agrees to reimburse the Plan for any payment made to or for the covered person in error.

Conformity With Government Law

If a provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Cost Sharing Provisions

Typically, these terms are used in the “Schedule of Benefits” section of the Plan. The Plan may use one or more of these terms.

“Deductible” generally means an amount which is reduced from eligible charges before benefits of the Plan are payable. It is the covered person’s responsibility to pay the deductible amount.

“Coinsurance” generally means the percentage of the eligible charges for covered services and supplies which the Plan will pay —subject to all of the provisions of the Plan. It is the responsibility of the covered person to pay for the percentage of coinsurance not payable by the Plan.

“Copayment” generally means a fixed amount of money that a covered person is required to pay toward the cost of a specified service or supply that is covered by the Plan.

“Non-compliance Penalty” generally means an amount that is reduced from eligible charges due to a failure to comply with specified provision requirements of the Plan. Any amount not covered by the Plan due to a non-compliance penalty is the responsibility of the covered person.

The covered person will also be responsible to pay for charges that the Plan will not cover such as those that exceed the Usual and Customary amount covered by the Plan for a service or supply, charges for amounts that relate to services or supplies that are not covered by the Plan and charges for amounts that exceed the Plan’s benefit maximums or plan maximums.

Duplication of Benefits

If any eligible charge is described as covered under two or more provisions within this Plan, the Plan will provide benefits based on the greater benefit. Only one benefit will be provided per covered expense.

Financing and Administration

No insurance company, insurance service, HMO or other state licensed entity is responsible for the financing or administration of the Plan. Benefits under the Plan are not guaranteed by a policy of insurance.

GENERAL INFORMATION

Master Plan Document

The Master Plan Document, including all its schedules, provisions, exclusions, limitations, appendices and any amendments contained thereto, constitutes the entire Plan.

Medical Care Provided By The United States

The Plan will reimburse eligible charges for medical care rendered by the Veteran's Administration for a non-service related illness or injury. The Plan will also reimburse eligible charges for medical care rendered by the United States to military retirees and dependents who are covered by this Plan on an inpatient basis.

New Drugs, Medical Tests, Devices and Procedures

The Plan does not distinguish between "new" drugs or pharmaceuticals, medical tests, devices and procedures and existing drugs or pharmaceuticals, medical tests, devices and procedures when determining whether the drugs or pharmaceuticals, medical tests, devices and procedures are covered. New and existing drugs or pharmaceuticals, medical tests, devices and procedures are covered as specified in the Schedule of Benefits or other medical services sections of the Plan, provided they are not excluded by any provision of the Plan.

Participant Contribution

A Participant Contribution is the amount an employee is required to pay in order to participate in the Plan. Contact your employer for contribution requirements. Individuals who are participating in the Plan by virtue of having exercised their rights under the section of the Plan entitled "Continuation of Coverage (COBRA)" will receive a separate notice which will indicate the cost to participate in the Plan.

Payments Directly To Providers

The Plan shall pay a provider directly for health services rendered by such provider to a covered person, unless otherwise specified by the employee.

Plan Amendment or Termination

While the Plan Sponsor expects and intends in good faith to continue the Plan for an indefinite period of time, it reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time. Such amendment or termination of the Plan shall be performed in writing and executed by an officer or other authorized individual of the Plan Sponsor. The Board of Directors of the Plan Sponsor either will have pre-approved or will later ratify by corporate resolution, including by general ratification, any such Plan amendment or termination of the Plan.

In the event the Plan is terminated, any covered expenses which have been incurred prior to the date of termination will be payable in accordance with the terms and conditions of the Plan. Plan assets will be allocated first to the payment of claims, and thereafter in a manner that is for the exclusive benefit of the participants, except that any taxes and administration expenses may be made from Plan assets.

Plan Interpretation

The Plan Administrator shall have all powers necessary to effectuate the provisions of the Plan. The Plan Administrator has contracted with D. Edward Wright, Inc. to process claims, maintain Plan data, and perform other Plan connected services. However, the Plan Administrator shall determine all questions arising in the administration, interpretation and application of the Plan, and shall, from time to time, formulate and issue such rules and regulations as may be necessary for the purpose of administering the Plan. Any interpretation, determination, rule, regulation, or similar action or decision issued by the Plan Administrator, or any person acting at its direction, shall be conclusive and binding on all persons, except as otherwise provided herein with any such determination, rule, regulation or similar decision not being set aside by a reviewing tribunal unless it is determined by a court of competent jurisdiction that the Plan Administrator acted in an arbitrary and capricious manner. Benefits will be paid under the Plan only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Is Not A Contract

The Plan shall not be deemed or constitute a contract between the employer and any employees or other persons or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer, or to interfere with or abridge the right of, the employer to discharge any employee at anytime.

Plan Maximums and Benefit Maximums

“Plan Maximums” generally means the total amount the Plan will pay for any covered person while he or she is a participant in the Plan, regardless of whether such coverage is continuous. (See the Schedule of Benefits section of the Plan for additional information.)

“Benefit Maximums” generally means the Plan limits an amount payable by the Plan for a service or supply. The limitation may be based, for example, on the number of services provided while the person is covered by the Plan or it may be determined on a periodic basis such as a set period of time or per occurrence of an illness or injury. These limitations may also be expressed in other terms, for example, a number of days, visits or confinements. (See the Schedule of Benefits section of the Plan for additional information.)

Plan’s Rights to Subrogation and Reimbursement

If a covered person incurs medical, dental, prescription drug or disability expenses for an illness or injury because of the fault, in whole or in part, of another person, that other person may be legally responsible for those medical, dental, prescription drug or disability expenses. Furthermore, a covered person or the covered person's guardian or estate may be entitled to receive money from an insurance contract for medical, dental, prescription drug or disability expenses resulting from an injury or illness. The Plan will be subrogated to all rights of recovery the covered person or the covered person’s guardian or estate may have against such other person or persons and such insurance contract or contracts for medical, dental, prescription drugs or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person or the covered person's guardian or estate.

GENERAL INFORMATION

The Plan shall have the right to receive payment or repayment of those expenses referred to above from the person or persons that caused the illness or injury, any person who has legal responsibility for that person, that person's liability insurer, or any other insurer providing coverage for that person. The Plan shall also have the right to recover expenses it has paid or is obligated to pay from amounts paid for those expenses referred to above from the covered person's or his or her guardian's or estate's auto insurance including but not limited to uninsured or underinsured motorist coverage and med pay.

The Plan shall have "dollar one" recovery entitlement from any amounts **paid** and not simply from amounts received, regardless of whether the covered person or his or her guardian or estate is "made whole".

The Plan is automatically assigned the covered person's or the covered person's guardian's or estate's right of recovery against third parties (including their insurers) who are responsible in whole or in part for causing the injury or illness, to the extent of amounts the Plan has paid or is legally obligated to pay for the medical, dental, prescription drug or disability expenses of the covered person. The Plan will be entitled, but not obligated, to proceed in the name of the covered person or the covered person's guardian or estate against the person or persons responsible to repay the Plan for expenses the Plan has incurred for the covered person as identified above, if the covered person or the covered person's guardian or estate fails to take the necessary action to recover such expenses.

The amount of the Plan's subrogation claim must be included in any litigation filed or any claim made or asserted by or for the covered person or the covered person's guardian or estate in connection with the injury or illness giving rise to the expenses referred to above including claims made against the covered person's own insurance. When the claim is settled or any amount is paid to the covered person, his or her legal representative, or guardian, or estate then the person receiving such funds must reimburse the Plan or cause the Plan to be reimbursed for medical, dental, prescription drug or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person.

The covered person or the covered person's guardian or estate shall not prejudice the Plan's rights of subrogation and reimbursement and shall sign and deliver documents to evidence or to secure those rights to the Plan. The Plan has the right to receive from the covered person or the covered person's guardian or estate, prior to the Plan's payment of claims or at any time subsequent thereto, a completed subrogation questionnaire, a reimbursement agreement and an acknowledgment of the Plan's subrogation and recovery rights signed by the covered person or the covered person's guardian or estate, or his or her authorized legal representative, on forms provided by the Plan.

The covered person, or the covered person's guardian, or estate is not authorized to obtain legal representation, to act on behalf of the Plan for recovery of any amounts paid by the Plan. Any contingent fee or retainer agreement entered into by the covered person or the covered person's guardian or estate will have no effect on the Plan's entitlement to the full amount of its subrogation claim on a "dollar one, first priority basis", regardless of any asserted offset for attorney fees or costs or other reduction unless specifically agreed to in writing by the Plan. This

GENERAL INFORMATION

also applies to any other similar federal or state common law which would cause the Plan to receive less than the full amount of its claim. The concept of the “common fund doctrine” that governs the allocation of attorney’s fees does not apply to this Plan or its rights to subrogation and recovery. The Plan may, at its discretion, enter into an agreement with the covered person his or her legal representative, guardian, or estate to represent its subrogation interest.

The Plan’s rights as provided in this “Plan’s Rights to Subrogation and Reimbursement” provision of the Plan document are created and preserved regardless of whether the covered person or the covered person’s guardian or estate is “made whole”, signs a reimbursement agreement, or signs an acknowledgment of the Plan’s subrogation and recovery rights. The covered person, the covered person’s guardian, estate, or legal representative shall make no distributions nor authorize any distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien or the expenses for medical, dental, prescription drug, or disability expenses that the Plan has paid or that it is legally obligated to pay to or on behalf of the covered person without the written approval of the Plan and shall not release any party or their insurer without the prior written approval of the Plan. In addition, the covered person, his or her guardian, estate, or legal representative will not withhold or intercept any amounts due the Plan from any party. Additionally, the covered person, his or her guardian, estate, or legal representative shall not instruct any party to forward amounts owed to the Plan, to any entity other than the Plan, in the absence of a prior written agreement with the Plan or its Third Party Administrator.

The subrogation rights of the Plan shall be superior to and the Plan shall have "first priority" over any competing claims of the covered person, his or her guardian, estate, or legal representative, or any competing claims of a parent, spouse, or child of a covered person, to any designated or undesignated proceeds of a judgment, award, or insurance settlement of the claims of the covered person, or of any other person where such settlement, judgment or award relates to or arises from the circumstances giving rise to the medical, dental, prescription drug or disability expenses of the covered person that the Plan has paid or that the Plan is legally obligated to pay to or on behalf of the covered person.

A covered person also includes any dependent of the covered person where applicable.

Presumption of Receipt of Information

It shall be presumed that any information, notification or decision, provided by the Plan through the U.S. Mail, to a covered person or provider located in the United States is received by the covered person or provider within three (3) days of the date of mailing.

Proof of Claim

Written proof of a claim must be submitted to the Plan by the covered person or the provider of service within six months after the date such claim is incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to provide written proof of the claim within the time required, except that no claim shall be eligible for payment if it is submitted more than 12 months from the date the claim was incurred. A claim shall be considered as incurred on the date the services or supplies are rendered or received.

Rescission of Coverage

The Plan has the right to rescind coverage for which the employee or covered person made a material misrepresentation on his or her application for coverage form or change notice form. To rescind means to cancel coverage effective on the date coverage was granted in reliance on the material misrepresentation. A material misrepresentation is an untrue statement which leads the Plan to cover the employee or a covered person or cover a medical condition of the employee or a covered person when it would not have done so if it had known the truth. The Plan will refund all contributions paid for any coverage rescinded, however claims paid will be offset from this amount. In addition, the Plan reserves the right to recover from the employee, covered person or provider of service the amount paid on claims incurred during the period for which coverage is rescinded.

Right of Recovery For Payments Made

The Plan reserves the right to recover payments made under the Plan in the amount by which the payments exceed the maximum amount required to be paid under the provisions of the Coordination of Benefits section or any other provisions of the Plan. In the discretion of the Plan Administrator, such recovery may include the reduction in the payment by the Plan of the future benefits properly payable under the Plan. This right of recovery applies against:

1. any person to whom, for whom, or with respect to whom such payments were made; or
2. any insurance companies or other organizations, which according to these provisions, provide benefits for the same allowable expense under any other plan.

Rights With Respect To Medicaid

Payment of benefits with respect to a covered person under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such covered person as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

In enrolling an individual as a covered person in the Plan or in determining or making any payments for benefits of an individual as a covered person, the fact that the individual is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account.

To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act for supplies, services or treatments for a covered person in those situations where the Plan has a legal liability to make such payment, the Plan will make payment for such benefits in accordance with any State laws which provide that the State has acquired the rights of a covered person for payment for such supplies, services or treatments.

Self-funding

This is a self-funded Plan which means claims are paid directly by the Plan Administrator from its assets. The Plan Administrator has entered into a legal arrangement with a Third Party

GENERAL INFORMATION

Administrator to assure accurate, impartial and timely payment of benefits to, and on behalf of, covered employees and their covered dependents.

Summary Plan Descriptions

The employer will issue to each covered employee or dependent, COBRA participant and retired employee (if retired employees are covered under the Plan), a Summary Plan Description which summarizes the benefits to which the covered person is entitled. The booklet is intended to satisfy the requirements of a Summary Plan Description, as specified in ERISA.

Usual and Customary Procedure

D. Edward Wright, Inc. will cover the amount which is usually and customarily charged for that type of service. The amount in excess of the usual and customary fee may be pended for additional information. The employee will be notified on the Explanation of Benefits or by letter that D. Edward Wright, Inc. is requesting additional information. D. Edward Wright, Inc. will then contact the provider, which will give the provider the opportunity to supply D. Edward Wright, Inc. with additional information which may explain the higher fee. This may include an operative report or medical records if signed authorization is received from the employee. If after receiving the additional information, the higher amount cannot be justified, D. Edward Wright, Inc. will outline the reasons for the denial.

Workers' Compensation

The Plan is not issued in lieu of, nor does it affect any requirement of coverage under any act or law which provides benefits for any injury or illness occurring during, or arising from, the employee's course of employment.

PLAN INFORMATION

EMPLOYER, PLAN ADMINISTRATOR AND NAMED FIDUCIARY:

HR America, Inc.
1833 Magnavox Way
Fort Wayne, Indiana 46804
219-436-3878

EMPLOYER IDENTIFICATION NUMBER:

62-1674287

PLAN NUMBER:

501

THE FOLLOWING COVERAGE IS INCLUDED IN THIS PLAN:

Comprehensive Dental Benefits

TYPE OF ADMINISTRATION:

Self-Funded Group Health Plan

THIRD PARTY ADMINISTRATOR:

D. Edward Wright, Inc.
111 West Ludwig Road, Suite 108
Fort Wayne, IN 46825-4217
(260) 969-4010

AGENT FOR SERVICE OF LEGAL PROCESS:

HR America, Inc. Dental Plan
c/o D. Edward Wright, Inc.
111 West Ludwig Road, Suite 108
Fort Wayne, IN 46825-4217
(260) 969-4010

COST:

The contributions necessary to finance the Plan are shared by the employer and the employee.

FINANCIAL RECORDS:

The financial records of the Plan are kept on a Plan Year basis ending on each December 31.

STATEMENT OF ERISA RIGHTS

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

1. examine, without charge at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
2. obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies; and
3. receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are certain steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

STATEMENT OF ERISA RIGHTS

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay court costs and legal fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.