

***PLAN DOCUMENT/SUMMARY PLAN
DESCRIPTION***

FOR THE

SCHREINER UNIVERSITY

DENTAL PLAN

Restated Effective Date: June 1, 2008

TABLE OF CONTENTS

I.	SCHEDULE OF DENTAL BENEFITS.....	2
II.	ELIGIBILITY REQUIREMENTS.....	3
III.	DEFINITIONS	12
IV.	DENTAL BENEFIT PROVISIONS	18
V.	COORDINATION OF BENEFITS	22
VI.	SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION.....	25
VII.	CONTINUATION OF BENEFITS (COBRA).....	26
VIII.	CLAIMS PROVISIONS	32
IX.	IMPORTANT INFORMATION.....	38
X.	HIPAA PRIVACY RULE.....	43
XI.	HIPAA SECURITY STANDARDS.....	46
XII.	ERISA RIGHTS	48
XIII.	PLAN DOCUMENT INFORMATION.....	50

<h2 style="margin: 0;">I. SCHEDULE OF DENTAL BENEFITS</h2>
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MAXIMUM BENEFIT PER CALENDAR YEAR* **\$1,000**

*The Maximum Benefit applies to all services except Orthodontic Treatment.
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LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC TREATMENT **\$1,000**

DEDUCTIBLE PER CALENDAR YEAR:

Per Covered Person:

Preventive and Diagnostic Services **None**
 Basic, Restorative, Major Services and Orthodontic Treatment Combined **\$50**

Family Deductible Limit:

Preventive and Diagnostic Services **N/A**
 Basic, Restorative, Major Services and Orthodontic Treatment Combined **\$100**

Once two individuals have satisfied the deductible, the deductible will not apply for any other family member's charges. Other family member's charges previously applied to the deductible will not be recalculated.

BENEFIT PERCENTAGE (payable by the Plan):

Preventive and Diagnostic Services **100%**
 Basic and Restorative Services **80%**
 Major Services **50%**
 Orthodontic Treatment** **50%**

**Orthodontic benefits are only available for dependent children up to age 19 or to age 24 if the child is a full-time student.
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WAITING PERIOD*:**

Preventive and Diagnostic Services **None**
 Basic and Restorative Services **None**
 Major Services **90 days**
 Orthodontic Treatment **None**

***The waiting period applies from the person's effective date of dental coverage before dental benefits are payable.

II. ELIGIBILITY REQUIREMENTS

A. EMPLOYEE ELIGIBILITY REQUIREMENTS

All full-time and $\frac{3}{4}$ time regular employees (normally working a minimum of **30** hours per week) are eligible to participate in the Plan on the **1st** day of the month following **30** days of regular full-time or $\frac{3}{4}$ time employment. An employee who is not actively at work for any reason *other than* due to health status-related factors on his scheduled effective date of coverage will not become covered under the Plan until such time as the employee returns to active employment.

Eligibility for benefits cannot be based on health status-related factors.

B. DEPENDENT ELIGIBILITY REQUIREMENTS

An eligible dependent who is a resident of the same country in which the Employee resides, includes the eligible employee's spouse (as defined by the Plan) unless divorced or legally separated (documentation proving a legal marital relationship may be required), and all unmarried children (as defined by the Plan) under **19** years of age. A married dependent child shall **not** be considered as an eligible dependent under this Plan.

In addition to the above, an unmarried child shall be considered as an eligible dependent from age **19** to age **24** if the child is a full-time student (as defined by the Plan), and if the child is principally dependent upon the eligible employee for support and maintenance. Semester breaks (including summer) will not jeopardize a child's full-time student status. However, if a child does not attend as a full-time student during the semester following the break, the child will no longer be considered an eligible dependent under the Plan. Coverage will terminate on the first day of the semester following the break. If the child must leave school during the school term due to illness or injury and, as a result, ceases to be a full-time student, the child will remain eligible to participate in the Plan through the end of the school term. If a child ceases to be a full-time student due to graduation, coverage will terminate upon the last day of the calendar month following the date of graduation.

An unmarried child who is incapable of self-sustaining employment by reason of mental retardation or physical handicap prior to attaining age **19** may be considered as an eligible dependent while remaining incapacitated and continuously covered under the Plan. To continue a child under this provision, proof of incapacity must be submitted within **30** days of the child's attainment of the age limit. Proof of continuing incapacity may be required by the Claims Administrator from time to time, but not more frequently than annually after the two-year period following the attainment of age **19**.

Any person who is covered as an eligible employee shall **not** be considered as an eligible dependent under this Plan. If both parties of a married couple work for the same company and one spouse is covered under this Plan as the other's dependent, he shall **not** also be covered as an employee. Also, if both parents are employed at the same company, children will be covered as dependents of one parent only.

If a covered dependent is eligible to be enrolled as an employee, enrollment may be effective on the first day of any month. If an employee is eligible to be enrolled as a dependent, enrollment may be effective on the first day of any month.

Any change in coverage status does not interrupt participation in the Plan and does not change a Covered Person's effective date of coverage for purposes of the "Pre-existing Condition" definition.

An employee must be covered under this Plan in order to cover any eligible dependents under this Plan.

The Plan Sponsor retains the right to request whatever documentation is necessary to confirm that a dependent meets the Plan's dependent eligibility requirements. If an employee is asked to certify the status of persons for which he is claiming dependent status and it is discovered that false information has been provided, coverage for the employee and his dependent(s) will be terminated, and the employee will be asked to reimburse the Plan. It is a Federal crime, under HIPAA, to provide false information in order to obtain benefits from a health plan.

Eligibility for benefits cannot be based on health status-related factors.

C. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Health coverage shall be provided to the child of an eligible employee who is the subject of a QMCSO in accordance with applicable law, or who is the subject of a National Medical Support Notice (NMSN) that is deemed to operate as a QMCSO.

The term "Alternate Recipient" means any child of an eligible employee who is recognized under a QMCSO as having a right to enrollment under a group health plan.

A QMCSO is a court order that usually results from a divorce that provides for child support or health care coverage for the child of an eligible employee. The court order creates or recognizes the existence of the alternate recipient's right to, or assigns to the alternate recipient the right to, receive benefits for which the employee is eligible under the Plan. The QMCSO must specify:

- the name and last known mailing address of the employee required to pay for the coverage and the name and mailing address of each alternate recipient;
- a reasonable description of the type of coverage to be provided by the Plan or the manner in which such coverage is to be determined;
- each Plan to which the order applies; and
- the period for which coverage must be provided.

The court order may not require a plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan.

When a Plan Administrator receives a medical child support order, the following steps must be taken. The Plan Administrator must:

- notify both the eligible employee and each alternate recipient of receipt of the order;
- furnish an explanation of the Plan's procedures for determining whether the court order is a QMCSO;
- determine if it is qualified; and
- notify the eligible employee and each alternate recipient of the determination and, if the order is determined to be qualified, provide the alternate recipient with a full explanation of the benefits hereunder.

The Plan Administrator is responsible for deciding whether the court order satisfies the conditions of a QMCSO.

D. ENROLLMENT REQUIREMENTS FOR EMPLOYEES AND DEPENDENTS

Coverage does not become effective until the eligible employee completes an enrollment form for himself and/or his eligible dependent(s). Eligible dependents enrolled after the effective date of this Plan will become covered on the same date as the eligible employee or the date the dependent is acquired, whichever is later. If the employee does **not** request enrollment for himself and/or his eligible dependent(s) within **30** consecutive days after satisfying the waiting period and becoming eligible to enroll in the Plan, then the employee may only request enrollment for himself and/or his eligible dependent(s) as follows:

1. if the employee, his spouse or dependent is entitled to special enrollment rights as required by HIPAA as follows:
 - during a special enrollment period for an employee who either initially declined coverage for himself and/or his eligible dependent(s) because of existing other health coverage, or who previously declined coverage for himself and/or his eligible dependent(s) at a subsequent opportunity to enroll under a special enrollment period or as a late entrant because of existing other health coverage, if the employee requests enrollment for himself and/or such dependents not later than **30** days after loss of the other health coverage provided that the other coverage was terminated due to:
 - loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the limiting age for a dependent child), death, termination of employment, or reduction in hours; or
 - an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual); or
 - an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
 - an individual incurring a claim that would meet or exceed a lifetime limit on all benefits (the special enrollment right begins when a claim that would exceed a lifetime limit on all benefits is incurred and continues until at least **30** days after the earliest date that a claim is denied due to the operation of the lifetime limit); or
 - a plan no longer offering any benefits to a class of similarly situated individuals; or
 - cessation of employer contributions for the other health coverage; or
 - the exhausting of COBRA continuation coverage.

If coverage is requested within **30** days of the loss of other health coverage as described above, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request. (However, if an

employee or dependent lost other coverage as a result of the individual's failure to pay premiums or for cause, such as making a fraudulent claim, that individual does not have a special enrollment right.)

- during a special enrollment period that occurs when a dependent is acquired as a result of marriage or birth, adoption, or adoptive placement of a child. An employee who acquires a new dependent may also enroll, with or without the dependent. An employee's spouse and/or other eligible dependents may also enroll as a result of such birth, adoption, or adoptive placement. The employee must request enrollment for himself and/or such dependent(s) within a **30-day** period which begins on the date of marriage, birth, adoption or adoptive placement (for enrollment provisions specific to a newborn or adoptive child, refer to "**Enrollment Requirements for Newborn or Adoptive Children**"). If coverage for newly acquired dependents is requested within the **30-day** special enrollment period, coverage under this Plan will become effective as follows: on the date of birth or adoption; or on the first day of the calendar month following the enrollment request for marriage.

2. upon the occurrence of a "change in status" which means any of the following events:

- change in employee's legal marital status including marriage, death of spouse, divorce, legal separation, or annulment;
- change in employee's number of dependents, including birth of a child, adoption or placement for adoption of a child, or death of a child;
- termination or commencement of employment by employee, his spouse or child;
- change in work schedule of employee, his spouse or child, including a switch between part-time and full-time status, a strike or lockout, or commencement of or return from an unpaid leave of absence, an FMLA leave (as required by FMLA), or absence on account of being in "uniformed service" (as defined under USERRA);
- a dependent satisfying or ceasing to satisfy the dependent eligibility requirements on account of attainment of a specified age, student status or similar circumstance; or
- change in place of residence or work of employee, his spouse or dependent.

The employee must request enrollment for himself and/or his eligible dependent(s) within a **30-day** period that begins on the date of the change in status event, provided that the change in status results in a gain or loss of coverage and the request for enrollment corresponds with such gain or loss coverage. If coverage is requested within **30** days of the "change in status" event, coverage under this Plan will become effective as follows: on the date of birth or adoption; or on the first day of the calendar month following the enrollment request.

The Plan Sponsor may administratively define other changes in circumstances as "changes in status" as long as any such definition is consistent with applicable laws, regulations, rulings and announcements of the Internal Revenue Service and is applicable to Covered Persons on a uniform, non-discriminatory basis.

3. as a result of a judgment, decree or order if such judgment, decree or order results from divorce, legal separation, annulment or change in legal custody (including a QMCSO) and requires the employee to provide health coverage for his child. The employee must request enrollment for the child within **30** days of the judgment, decree or order (or, in

the event of a QMCSO, as required by Federal law). If coverage is requested within **30** days of the judgment, decree or order, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request. If an eligible employee who is **not** covered under this Plan is required to provide health coverage for his child as a result of a judgment, decree or order, the employee must request coverage for himself within **30** days of the judgment, decree or order (or in the event of a QMCSO, as required by Federal law) in order to cover his child under this Plan.

4. as a result of termination of entitlement to Medicare and Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act that provides for the distribution of pediatric vaccines) provided that the employee requests enrollment for himself and/or his eligible dependent(s) within a **30**-day period which begins on the date that the termination of entitlement to Medicare or Medicaid occurs. If coverage is requested within **30** days of termination of entitlement to Medicare or Medicaid, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request.
5. as a result of a significant change (increase or decrease) in cost or significant curtailment of coverage (with or without a loss of coverage) provided that the employee requests enrollment for himself and/or his eligible dependent(s) within a **30**-day period which begins on the date that the significant change in cost or significant curtailment of coverage occurs. If coverage is requested within **30** days of the date that the significant change in cost or significant curtailment of coverage occurs, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request.
6. as a result of a significant change in health coverage attributable to a spouse's or dependent's employment provided that the request for enrollment is necessary or appropriate as a result of the significant change. The employee must request enrollment for himself and/or his eligible dependent(s) within a **30**-day period which begins on the date that the significant change in health coverage occurs. If coverage is requested within **30** days of the date that the significant change in health coverage as described above occurs, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request.
7. as a result of an addition or significant improvement of a benefit package option provided that the employee requests enrollment under the new or improved benefit package option for himself and/or his eligible dependent(s) within a **30**-day period which begins on the date that the new or improved benefit package option is offered. If coverage is requested within **30** days of the date that the addition or significant improvement as described above occurs, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request.
8. as a result of a change in coverage under another employer plan (including, but not limited to, a change made as a result of an open enrollment period under the other employer's plan), provided that the employee requests enrollment for himself and/or his eligible dependent(s) within a **30**-day period which begins on the date that the change in the other employer's plan occurs, and further provided that the change is made on account of, and corresponds with, the change made by the spouse or dependent under the plan maintained by that individual's employer. If coverage is requested within **30** days of the date that the change in the other employer's plan occurs, coverage under

this Plan will become effective on the first day of the calendar month following the enrollment request.

9. as a result of a loss of coverage under other group health coverage sponsored by a governmental or educational institution (including the following: a State children's health insurance program [SCHIP] under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a foreign government group health plan), provided that the employee requests enrollment for himself and/or his eligible dependent(s) within a **30-day** period which begins on the date that the loss of coverage under other group health coverage occurs. If coverage is requested within **30** days of the date the loss of coverage under such other group health coverage occurs, coverage under this Plan will become effective on the first day of the calendar month following the enrollment request.
10. as a late entrant as defined by the Plan but **only** during an open enrollment period held once each year at a time established by the Plan Sponsor.

Every June, the annual open enrollment period, covered Employees will be able to change some of their benefit decisions based on which benefit and coverage are right for them. Every June during the open enrollment period, Employees and their Dependents who are late entrants will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is a change in family status during the year (death, birth, marriage, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage waiting periods and pre-existing condition limits, credit will be given for that portion that has been met when changing from one plan to another plan.

Benefit choices for late entrants made during the open enrollment period will become effective July 1. A Plan participant who fails to make election during an open enrollment period will automatically retain his present coverage.

E. ENROLLMENT REQUIREMENTS FOR NEWBORN OR ADOPTIVE CHILDREN

A newborn or adoptive child of a covered employee is covered from the date of birth or the date the child is placed with the employee pending final adoption if coverage for the child is requested no later than **30** days after the date of birth or date of adoptive placement and any required premium contributions are made.

If coverage for the child is **not** requested within the **30-day** period, the child may only be enrolled as provided in "**Enrollment Requirements for Employees and Dependents.**" **If the employee does not have dental coverage** under this Plan at the time coverage for the child is requested, the employee and child may only be enrolled as provided in "**Enrollment Requirements for Employees and Dependents.**"

F. FAMILY AND MEDICAL LEAVE ACT (FMLA) OF 1993

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, coverage under this Plan will be continued in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Any required contributions are paid; and
- the employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- the leave period required by the federal Family and Medical Leave Act of 1993, as amended; or
- the leave period required by applicable state law.

An employee can choose not to retain group health coverage during an FMLA leave. When the employee returns to work following the FMLA leave, the employee's coverage will usually be restored to the level the employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed.

This section is intended as a summary of the FMLA, not as a complete interpretation of the law.

G. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) OF 1994

The Plan shall fully comply with USERRA. If any provision of this Plan is found to be in conflict with USERRA, the conflicting provision shall be reformed, to the full extent practicable, to conform to the requirements of USERRA and any provision which is still in conflict will be void and of no further force or effect. All other benefits and exclusions of the Plan will remain effective to the extent that there is no conflict with this Act.

H. COVERAGE IN THE EVENT OF:

- **DISABILITY:** If a covered employee becomes totally disabled, coverage may be continued under COBRA. See "**CONTINUATION OF BENEFITS (COBRA)**" for coverage continuation options.
- **FAMILY AND MEDICAL LEAVE ACT (FMLA) LEAVE OF ABSENCE:** If a covered employee's active work ceases due to an approved FMLA Leave, the Employer may, while the Plan is in force, continue the covered employee's coverage during the period after cessation of active work, but not to exceed a period of **12** weeks, provided any required employee contributions are made. The covered employee may elect to: pre-pay the required employee contributions; pay the employee contributions on the same schedule as such contributions would have been due had the leave not been taken; or agree with the Employer in writing to reimburse the Employer for such employee contributions upon his return following the leave or upon his notice to the Employer during the leave that he will not be returning to work. If the employee notifies the Employer during the leave that he will not be returning to work, the covered employee's coverage under this Plan shall terminate on the day following the date on which such notice was given to the Employer.
- **LAPSE IN COVERAGE:** For the purpose of coverage under this Plan, if a previously covered person requests enrollment when there has been a lapse in coverage, the person may **only** be enrolled as provided in "**Enrollment Requirements for Employees and Dependents**" (except in the case that COBRA has been elected and continued with no lapse in coverage).
- **LEAVE OF ABSENCE OTHER THAN FMLA LEAVE OR USERRA LEAVE OR TEMPORARY LAYOFF:** A covered employee who takes a leave of absence other than a FMLA Leave or a USERRA Leave or a temporary layoff may continue to be covered under the Plan at the option of the Plan Sponsor for up to **90 days** while on such leave

or layoff, subject to the payment of any required contributions, provided the covered employee otherwise complies with the Employer's leave of absence policies and procedures. At the end of this 90-day period, the employee's employment will be deemed to have terminated for purposes of "Continuation of Benefits" under COBRA.

- **REHIRED EMPLOYEES:** For the purpose of coverage under this Plan, if a previously covered employee is rehired **within 3 months** of his termination date, the employee's coverage will be effective on his rehire date, provided he otherwise meets the eligibility requirements under the Plan on his rehire date. If an employee is rehired **within 3 months** of his termination date but such employee was not covered under the Plan previously due to the Plan's waiting period requirement or because the employee did not meet the Plan's requirement for minimum number of hours worked, he will be considered the same as a new employee. If a previously covered employee is rehired **more than 3 months** from his termination date, he will be considered the same as a new employee (except in the case that COBRA has been elected and continued with no lapse in coverage).
- **SEVERANCE:** If a covered employee's employment is terminated and there is a severance agreement for such employee, his coverage under this Plan may only be continued as specified under the "**CONTINUATION OF BENEFITS (COBRA)**" section.
- **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) LEAVE OF ABSENCE OF LESS THAN 31 DAYS:** If a covered employee is called to a USERRA Leave and the duration of the USERRA Leave is less than 31 days, then the covered employee and his covered dependents may continue to be covered under this Plan during such USERRA Leave by paying the portion of the premium for the coverage that the employee would have paid if the employee had continued in the same position and had not taken the USERRA Leave.
- **UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) LEAVE OF ABSENCE OF 31 DAYS OR MORE:** If a covered employee is called to a USERRA Leave and the duration of the USERRA Leave is equal to or greater than 31 days, then the covered employee and his covered dependents may continue to be covered under this Plan during such USERRA Leave up to the maximum period of coverage described below by paying the COBRA premium determined under the COBRA section of the Plan for such coverage. The maximum duration of continued coverage available for a USERRA Leave that equals or exceeds 31 days shall be the lesser of: the **18-month** period (**24-month** period for elections made on or after December 10, 2004) beginning on the date on which the covered employee's absence for the USERRA Leave commenced; or the day after the date on which the covered employee on the USERRA Leave fails to apply for or return to a position of employment with the Employer, as determined under USERRA.

I. TERMINATION WITH RESPECT TO EMPLOYEES

An employee's coverage under the Plan shall terminate on the earliest of the following dates:

- the date of termination of the Plan;
- the last day of the calendar month in which employment terminates, except as provided in "**Coverage in the Event of**";
- the last day of the calendar month in which an employee ceases to meet the Plan's eligibility requirements for employees, except as provided in "**Coverage in the Event of**";

- the date all coverage or certain benefits are terminated for a particular class by modification of the Plan;
- the date an eligible employee becomes a full-time member of the armed forces, except as required by USERRA;
- the last day of the calendar month for which the required contribution has been paid if the required contribution for the next period is not paid when due;

See “**CONTINUATION OF BENEFITS (COBRA)**” for coverage continuation options.

J. TERMINATION WITH RESPECT TO DEPENDENTS

A dependent’s coverage shall terminate under the Plan on the earliest of the following dates:

- the date of termination of the Plan;
- the date of termination of all coverage under the Plan with respect to dependents;
- the date the employee’s coverage terminates for any reason, except as provided in “**Coverage in the Event of**”;
- the date the dependent becomes covered under the Plan as an employee;
- the date the dependent becomes a full-time member of the armed forces, except as required by USERRA;
- the last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due;
- the last day of the calendar month in which the person ceases to meet the Plan’s eligibility requirements for dependents, except as provided in “**Coverage in the Event of.**”

See “**CONTINUATION OF BENEFITS (COBRA)**” for coverage continuation options.

III. DEFINITIONS

NOTE: Throughout this document, any references to the terms “he,” “him,” or “his” shall also mean “she,” “her,” or “hers.”

“Accidental Injury” means accidental bodily injury caused by unexpected external means, resulting, directly and independently of all other causes, in necessary care rendered by a physician.

“Actively at Work” means the active expenditure of time and energy in the service of the Employer, except that an employee shall be deemed actively at work on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

“Amendment” means a formal document that changes the plan document, duly signed by the authorized person as designated by the Claims Administrator.

“Beneficiary” means a dependent who is covered under this Plan.

“Benefit Percentage” means the portion of eligible expenses payable by the Plan in accordance with the coverage provisions as stated in the Plan.

“Calendar Year” means January 1 through December 31 of the same year. For new employees and dependents, a Calendar Year begins on the person’s effective date and runs through December 31 of the same year.

“Children” means the employee’s natural children, legally adopted children (including children placed for adoption for whom legal adoption proceedings have been started), step-children who reside in the employee’s household (unless a full-time student away at college), alternate recipients under Qualified Medical Child Support Orders, and any other child for whom the eligible employee has obtained legal guardianship and who is living with the eligible employee in a regular parent-child relationship. Foster children are not considered as eligible dependent children under this Plan. A grandchild who resides in the employee’s household is also considered as an eligible dependent under this Plan if the child may be legally claimed by the employee as a Federal income tax deduction.

“Claims Administrator” means the Claims Administrator as set forth in the **“IMPORTANT INFORMATION”** section.

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“Code” means the Internal Revenue Code of 1986, as amended from time to time.

“Common Fund” means a legal doctrine that, if applied, may allow a private attorney to reduce the Plan’s subrogation lien by costs and attorney’s fees, typically equal to one third of the lien.

“Covered Person” means any employee or dependent covered under this Plan.

“Creditable Coverage” means prior continuous health coverage and includes prior coverage under:

- a. another group health plan;
- b. group or individual health insurance coverage issued by a state regulated insurer or an HMO;
- c. COBRA;
- d. Medicaid;
- e. Medicare;
- f. State Children’s Health Insurance Program (SCHIP);
- g. the Active Military Health Program;
- h. Tricare/CHAMPUS;
- i. American Indian Health Care Programs;
- j. a State health benefits risk pool;
- k. the Federal Employees Health Plan;
- l. the Peace Corp Health Program; or
- m. a public health plan, including plans established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government, or a foreign country that provides health coverage to individuals who are enrolled in the plan (for example, coverage through the United States Veterans Administration and coverage from a state or federal penitentiary).

“Deductible” means the amount of covered dental expenses which must be paid by a Covered Person each calendar year before benefits are payable under this Plan. A separate deductible applies to a covered employee and each of the employee’s dependents, subject to the family deductible limit.

“Dentist” means a currently licensed dentist practicing within the scope of the license or any other physician furnishing dental services which the physician is licensed to perform.

“Effective Date,” when applied to a person’s coverage under the Plan, means the first day of the person’s coverage. The person’s effective date may or may not be the same as the person’s enrollment date (as “enrollment date” is defined by the Plan).

“Employee” means a person who is directly employed by the Employer on a full-time or $\frac{3}{4}$ time basis (who is regularly scheduled to work at least **30** hours per week), and who is performing his customary duties at the Employer’s facility or other location designated by the Employer. The term “Employee” shall exclude any person who works with or on behalf of the Employer from time to time either on a temporary basis, as a leased employee or as an independent contractor.

“Employer” means the Plan Sponsor and any entity that is affiliated with the Plan Sponsor within the meaning of Section 414 (b), (c), or (m) of the Code, that adopts this Plan for the benefit of its Employees, whose participation in the Plan is approved by the President (or any other duly authorized officer of the Plan Sponsor).

“Enrollment Date” means the first day of a person’s coverage or, if there is a waiting period before a person’s coverage becomes effective, the first day of the waiting period. For a person who enrolls during a special enrollment period (or as a late entrant), the enrollment date is the first day of the person’s coverage.

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Experimental or Investigational” means one or more of the following is true of a treatment, procedure, device, drug or medicine:

- a. It cannot be lawfully marketed without U.S. Food and Drug Administration approval, and approval for marketing for the condition treated has not been given at the time the device, drug or medicine is furnished.
- b. Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, and/or efficacy (or efficacy as compared with the standard means of treatment or diagnosis): (1) it is undergoing phase I, II, or III clinical trials or is under study; or (2) further clinical trials or studies are needed, according to the experts’ consensus of opinion. Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug or medicine).

“FMLA” means the Family and Medical Leave Act of 1993, as amended.

“FMLA Leave” means a leave of absence taken by an employee in accordance with the Family and Medical Leave Act of 1993, as amended.

“Family Deductible Limit” applies when two Covered Persons in the same family meet the individual deductible. When the family deductible limit is satisfied, no further deductibles need to be satisfied in the calendar year.

“Full-time Student” means a student attending high school or an accredited college, university or institution offering post high school education for the minimum number of credit hours required by such college, university or institution in order to maintain full-time student status.

“Health Status-related Factors” includes these eight (8) categories: health status, medical condition (both physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“Illness” means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term “illness” when used in connection with a newborn child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

“Immediate Family” means a person who is related to a Covered Person, whether the relationship is by blood or exists in law, limited to a spouse, parent, grandparent, child, brother or sister.

“Incurred” means the date a treatment, service or supply is provided to a Covered Person.

“Late Entrant” means a person who enrolls *other than* during the initial enrollment period or a special enrollment period as provided under the **“ELIGIBILITY REQUIREMENTS”** of the Plan.

“Leased Employee” means an individual who is not paid through an Employer’s payroll and who is typically compensated by a company (e.g., an employee leasing company or temporary

agency) other than the Employer. Leased employee includes (but is not limited to) individuals described in Code section 313 (n).

“Lifetime” means while a person is covered under this Plan. Lifetime does not mean during the lifetime of the Covered Person.

“Made-Whole” means a legal doctrine that attempts to place a value on a person’s injuries in order to determine whether that person has been fully compensated by any monetary recovery he might receive in a law suit or settlement. The doctrine, if applied, may allow a court to reduce or extinguish a Covered Person’s reimbursement obligation.

“Maximum Benefit,” means the total amount of dental benefits payable under this Plan on behalf of a Covered Person during any calendar year (unless specified otherwise).

“Medical Emergency” means an illness or injury which occurs suddenly and unexpectedly, requiring immediate dental care and use of the most accessible hospital equipped to furnish care to prevent the death or serious impairment of the Covered Person. Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency dental care rendered in accident cases and other acute conditions. For purposes of benefits payable under this Plan, the Claims Administrator will determine the existence of a medical emergency.

“Medically Necessary” means the expense incurred upon the recommendation and approval of a physician for the dental services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the patient and the physician shall not bind the Plan in determining its liability with respect to necessary expenses. These incurred expenses must be:

- a. consistent with the symptoms of diagnosis and treatment of the condition, illness, or injury;
- b. appropriate with regard to standards of good dental practice;
- c. not primarily for the convenience of the patient, the physician or other provider;
- d. the most appropriate level of services which can safely be provided to the patient. When applied to an inpatient, it means that the patient’s dental symptoms or conditions require that the services or supplies cannot be safely provided to the patient as an outpatient.

The fact that a physician might prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary or make the charge an allowable expense under the Plan, even though it is not specifically listed as an exclusion.

The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary.

“Medicare” means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

“Participant” or **“Plan Participant”** means an employee who is covered under this Plan.

“Physician” means a duly licensed doctor of medicine (M.D.) a doctor of osteopathy (D.O.), a licensed podiatrist (D.P.M.), a doctor of optometry (O.D.), and any other licensed practitioner who is required to be recognized for health insurance by law or regulation and is acting within

the scope of his license. The definition also includes a certified Nurse Midwife acting within the scope of their license, under the direction and supervision of a licensed Physician.

“Plan,” whenever used herein without qualification, means the Dental Plan of **Schreiner University** as described in this Plan Document/Summary Plan Description, and as it may be amended from time to time.

“Plan Administrator” means the Plan Sponsor.

“Plan Sponsor” means Schreiner University.

“QMCSO” means a Qualified Medical Child Support Order in accordance with applicable law.

“Spouse” means the person recognized as the covered employee’s husband or wife under the laws of the state where the covered employee lives. Documentation proving a legal marital relationship may be required. A common law spouse will meet the definition of a spouse when the Claims Administrator has received a statement of Declaration of Common Law Spouse which has been completed by both the employee and spouse.

“Temporomandibular Joint Dysfunction (TMJ)” means jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex muscles, nerves and other tissues related to the temporomandibular joint.

“Totally Disabled” as applied to an employee means (unless specifically provided otherwise) the complete inability of an employee to substantially perform the important daily duties of the employee’s own occupation, for which the employee is reasonably suited by education, training or experience. As applied to a dependent, the term means the dependent is prevented solely because of a non-occupational injury or non-occupational disease from engaging in all of the normal activities of a person of like age and sex and in good health.

“Treatment Plan” means a program of dental care and treatment planned in written outline by a dentist upon examination of a Covered Person.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

“USERRA Leave” means a leave of absence taken by an employee for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

“Usual and Customary Charges” means those charges made for dental services and/or supplies essential to the care of a Covered Person which will be considered usual and customary if they are the amount normally charged by the service provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received, as set forth by the Claims Administrator per industry-accepted guidelines. In determining whether charges are usual and customary, due consideration will be given to the nature and severity of the condition being treated and any dental complications or unusual or extenuating circumstances.

The Plan Administrator has the discretionary authority to decide whether a charge is usual and customary.

“Usual and Customary Charges” shall also mean those charges made for drugs, including chemotherapy, that are essential to the care of a Covered Person, which will be considered as usual and customary if they do not exceed the average wholesale price plus 10%.

Charges of a participating network provider will not be subject to usual and customary charge limitations, but to negotiated fees instead.

“**Waiting Period**” means the period that must pass under this Plan (or for the purpose of determining Creditable Coverage the waiting period under any other health plan) before an Employee or Dependent is eligible to enroll in the Plan.

IV. DENTAL BENEFIT PROVISIONS

Dental coverage under this Plan is limited to the necessary, usual and customary charges, subject to the application of maximum benefit, deductible, and benefit percentage provisions as stated in the “**SCHEDULE OF DENTAL BENEFITS.**”

A. COVERED DENTAL EXPENSES

PREVENTIVE AND DIAGNOSTIC SERVICES:

- routine oral examination, limited to **1** examination during any period of **6** consecutive months;
- prophylaxis treatment (scaling and polishing of teeth), limited to **1** treatment during any period of **6** consecutive months;
- topical application of sodium or stannous fluoride up to age **19**, limited to **1** application during any period of **12** consecutive months;
- topical application of a sealant on each permanent posterior tooth up to age **16**, limited to **1** application during any period of **12** consecutive months;
- space maintainers up to age **18**;
- dental X-rays including:
 1. full mouth series, limited to **1** series during any period of **24** consecutive months;
 2. panoramic view, limited to **1** during any period of **24** consecutive months;
 3. bitewing X-ray series, limited to **1** series during any period of **6** consecutive months;
 4. periapical X-rays.

BASIC AND RESTORATIVE SERVICES:

- non-routine office visit during regular office hours for treatment and observation of injuries to teeth and supporting structures;
- non-routine dental consultation (by other than dentist providing the treatment);
- non-routine office visit during regular office hours for treatment and observation of injuries to teeth and supporting structure other than for routine operative procedures;
- non-routine professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater);
- all other X-rays as needed for diagnosis
- emergency or palliative visits for relief of pain;
- diagnostic casts;
- biopsy and examination of oral tissue;
- extractions;
- oral surgery (surgical removal of impacted teeth is covered under the medical plan if the covered person is only enrolled in the medical portion of the plan);
- stainless steel crowns;
- endodontics including root canal therapy;
- amalgam, silicate, acrylic or plastic fillings;

- local anesthetics and antibiotic drugs injected by the attending dentist;
- anesthesia in conjunction with surgical procedures;
- subgingival curettage, alveolar and gingival reconstruction, periodontal scaling and root planing, gingivectomy, gingivoplasty, osseous surgery, musogingival surgery, occlusal adjustment performed in conjunction with periodontal surgery (per four quadrants within **12** consecutive months), or other treatment of periodontal abscess and periodontitis;
- relining and rebasing of dentures allowable only after **5** months from installation of original appliance. Allowance for relines or rebases adjustment within **6** months. After the initial installment adjustment period, upper or lower denture including full and partial relinement limited to once in a period of **12** consecutive months.

MAJOR SERVICES:

- inlays, onlays, gold fillings, crowns (except for stainless steel crowns), and gold dowel pins;
- repair or recementing of crowns, inlays, bridgework or dentures;
- occlusal guards – allowance includes all adjustments within **6** months and in conjunction with periodontal surgery;
- initial installation of partial or full removable dentures or fixed bridgework (including the accompanying inlays and crowns to form abutments) to replace one or more natural teeth extracted while the coverage is in effect under the Dental benefits portion of this Plan;
- replacement of existing partial or full removable dentures or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if:
 1. the replacement or addition of teeth is required to replace one or more natural teeth extracted while the coverage is in effect under the Dental benefits portion of this Plan and after the existing denture or bridgework was installed; or
 2. the existing denture or bridgework was installed at least **5** years prior to its replacement and cannot be made serviceable; or
 3. the existing denture is an immediate temporary denture, and replacement by a permanent denture is required and takes place within **12** months from the date of installation of the immediate temporary denture.

ORTHODONTIC TREATMENT:

The Plan will provide benefits for orthodontic treatment on dependent children under age **19**, subject to any limitations specified in the “**SCHEDULE OF DENTAL BENEFITS.**”

- oral examinations and diagnosis;
- initial (and subsequent, if any) installation of orthodontic appliances and adjustment of orthodontic appliances;
- comprehensive full-banded treatment;
- all other orthodontic treatment required by accepted orthodontic practice, including tooth extraction and dental X-rays.

B. GENERAL DENTAL PROVISIONS

PRE-TREATMENT PROCEDURES:

If charges which would be payable for a proposed course of dental care will exceed a total of **\$300.00**, written notice outlining such course and including charges should be forwarded to the Claims Administrator for assessment and certification prior to the commencement of any work or treatment. The Claims Administrator will determine and certify in writing the maximum

amount of work or treatment and charges for which payment will be made. This certification is not a guarantee of payment. *Any pre-certification of charges previously issued to a Covered Person will be of no effect after the date such person's coverage under this Plan terminates.*

“SERVICES INCURRED” AND “SERVICES PERFORMED”:

Charges shall be allocated to a particular calendar year and to the deductible or maximum applicable to such year, in accordance with the date such charge is deemed “incurred” under this contract. All charges which are “incurred” with respect to any treatment plan shall be deemed “incurred” on the date the service is actually “performed.”

C. DENTAL EXCLUSIONS

No benefits will be paid under this Plan for:

1. expenses that are excluded under the Plan's general exclusions as listed in the “**EXCLUSIONS**” section.
2. expenses payable under the Medical Benefit provisions of this Plan.
3. treatment by other than a dentist, except that scaling or cleaning of teeth may be performed by a licensed dental hygienist if treatment is rendered under a dentist's supervision and direction.
4. dentures and bridgework (including crowns and inlays forming abutments) when such charges are incurred for replacement of teeth, all of which were extracted while the person was not covered under the Dental benefits portion of this Plan.
5. implants and related appliances.
6. surgical removal of implants.
7. replacement of implants.
8. prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered before, or while, the person was covered under the Dental benefits portion of this Plan, but installed or delivered more than **30** days after termination of his Dental coverage under this Plan.
9. replacement of a lost or stolen prosthetic device or duplicate prosthetic appliances.
10. plaque control or oral hygiene.
11. cosmetic surgery or dentistry for cosmetic reasons; treatment for congenital (hereditary) or developmental malformations; cleft palate; maxillary or mandibular (upper and lower jaw) degeneration; enamel hypoplasia (lack of development); fluorosis.
12. temporomandibular joint (TMJ) dysfunction.

13. services furnished to the Covered Person by a medical department, clinic, or similar facility provided or maintained by such Covered Person's Employer.
14. which do not meet or are not necessary according to accepted standards of dental practice, including services or supplies which are experimental in nature.
15. drugs or medicine.
16. appliances or restorations, other than full dentures, whose primary purpose is to increase vertical dimension, restore occlusion, or stabilize periodontally involved teeth.
17. facings on pontics or crowns posterior to the second bicuspid.
18. replacement or repair of an orthodontic appliance.
19. functional/myofunctional therapy.
20. periodontal splinting.
21. labial veneers.
22. inhibiting appliances to correct harmful habits like bruxism or thumbsucking, such as occlusal guards (night guards);

V. COORDINATION OF BENEFITS

A. DEFINITIONS

The following definitions will apply **only** to this section:

1. **“This Plan”** means any health benefits described in this Plan Document.
2. **“Plan”** means any of these that provides benefits or services for, or because of, health care or treatment:
 - group insurance and group-type coverage, whether insured or uninsured. This includes group or group-type coverage through HMO’s and other prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage;
 - Blue-Cross and/or Blue-Shield group coverage;
 - coverage through labor-management trusteed plans;
 - government program coverage for which a person is eligible. This includes Medicare, both Parts A and B; however, Medicaid is excluded;
 - no-fault automobile insurance.

The term “plan,” as defined in this section, shall not be applicable to any coverage held by the Covered Person for hospitalization and/or medical-surgical expenses written as part of or in conjunction with any automobile insurance policy, unless it is a no-fault automobile insurance policy.

3. **“Allowable Expenses”** shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under This Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the list of “Exclusions.”

B. EFFECTS OF BENEFITS

1. The benefit payable under This Plan shall be integrated with the benefit payable for a Covered Person under all other plans. This Plan will: (1) determine the amount of benefits it would have paid had it been the person’s only coverage (with the exception that This Plan will base its determination of Allowable Expenses upon the greatest PPO provider discount among all plans of the Covered Person for the same charges); (2) subtract the amount of benefits payable by other plans that determine benefits before This Plan; and (3) pay the difference, if any. If the other plans that determine benefits before This Plan pay as much as, or more than, This Plan would have paid had it been the person’s only coverage (except as described above in regards to PPO provider discounts), then This Plan will not pay any benefits.
2. The rules for deciding which plan determines benefits first are:
 - a. The benefits of a plan that has no rules for coordination with other benefits are determined before This Plan’s benefits.

- b. The benefits of a plan that covers the person as an employee, member or subscriber, that is, other than a dependent, are determined before those of the plan that covers the person as a dependent.
- c. Except as stated in paragraph d. below, when This Plan and another plan cover the same child as a dependent of different persons, called "parents":
 - 1) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
 - 2) but if both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
 - 3) however, if the other plan does not have the rule described in 1), but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- d. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - 1) first, the plan of the parent with custody of the child;
 - 2) then, the plan of the spouse of the parent with the custody of the child; and
 - 3) finally, the plan of the parent not having custody of the child.

However, if a court decree states that one of the parents is financially responsible for the health care expenses, the benefits of that plan are determined first.

- e. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- f. If a person whose coverage is provided under a right of continuation pursuant to Federal or state law is also covered under another plan, benefits for such person are determined in this order:
 - 1) first, the benefits of the plan covering the person as an employee, member or subscriber (or as that person's dependent);
 - 2) second, the benefits under the continuation coverage.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- g. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, member or subscriber longer are determined before those of the plan which covered that person for the shorter time.

C. COORDINATION WITH MEDICARE

If an active employee covered by This Plan is age **65** or older and has Medicare Part A, This Plan is the primary payer and Medicare is the secondary payer of benefits provided under both This Plan and Medicare Part A or B. The same applies to a covered spouse if the spouse of an active employee is age **65** or over and has Medicare Part A, or if the spouse is employed and is age **65** or over and has Medicare Part A.

When a Covered Person is eligible for Medicare, Medicare will pay primary, secondary or last to the extent stated in Federal law. When Medicare is the primary payer, This Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

D. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Claims Administrator may release or obtain any information if it is deemed necessary to implement this section or if it is deemed necessary for similar sections of other plans. Such information does not require prior notice or consent. Any person who claims benefits under This Plan shall give the Claims Administrator any necessary information required.

E. FACILITY OF PAYMENT

Whenever payments which should have been made under This Plan in accordance with this provision have been made under any other plans, the Claims Administrator reserves the right to decide whether or not to reimburse the organization making the payment and the amount to be paid in order to satisfy the intent of this provision. Any such payment made will fulfill the Plan Sponsor's responsibility to the extent of such payment.

F. RIGHT TO RECOVERY

If the Claims Administrator makes an overpayment because of this or a similar section, the Claims Administrator has the right to recover the excess amount from any of the following sources: any person to whom payments are made, any other insurance companies, or any other organizations.

VI. SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

The Plan includes a Subrogation, Reimbursement and Third Party Recovery Provision. When this provision applies is described below:

If an employee, dependent, or anyone who receives benefits under this Plan becomes ill or is injured and entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Covered Person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the Covered Person retains an attorney, then the Covered Person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The Covered Person agrees to sign any documents requested by the Plan including, but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Covered Person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Covered Person and their attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by the Covered Person and not the Plan.

The Covered Person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the Covered Person, then the Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of the provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny future benefits on the basis of any recovery received, but not reimbursed, by the Covered Person as it relates to an accident or injury for which the Plan has paid benefits.

If the Covered Person takes no action to recover money from any source, then the Covered Person agrees to allow the Plan to initiate its own direct action for reimbursement.

VII. CONTINUATION OF BENEFITS (COBRA)

Continuation of health coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) shall not duplicate health coverage continued under any state or Federal law.

A. DEFINITIONS

As used in this provision, the following terms shall mean:

1. **“Entitlement to Medicare”** or **“Entitled to Medicare”** means the covered employee has enrolled in either Medicare Part A or Part B.
2. **“Qualified Beneficiary”** means:
 - a. a covered employee, for termination or reduced hours;
 - b. a spouse or a dependent child who were covered dependents under the Plan on the day before the covered employee’s Qualifying Event occurred;
 - c. a child who is born to a covered employee, or placed with a covered employee for adoption, during a period of COBRA continuation coverage.
3. **“Qualifying Event”** for a covered employee means a loss of coverage due to:
 - a. termination of employment for any reason other than gross misconduct;
 - b. reduction in hours of employment.

“Qualifying Event” for a covered dependent means a loss of coverage due to:

- a. a covered employee’s termination of employment (for any reason other than gross misconduct) or reduction in hours of employment;
- b. a covered employee’s death;
- c. a spouse’s divorce or legal separation from a covered employee;
- d. a covered employee’s entitlement to Medicare;
- e. a dependent child’s loss of dependent status under the Plan.

Termination of employment following a Qualifying Event that is a reduction in hours of employment is **not** a second Qualifying Event entitling the Qualified Beneficiary to an extension of the period of COBRA coverage continuation.

4. **“Timely contribution payment”** means that the required contribution payment is made within the applicable time period (for the initial contribution payment, within **45** days of the date that the Qualified Beneficiary made the initial election for continuation coverage; for subsequent contribution payments, within **31** days of the due date). A timely contribution payment is deemed to have been made if it is not significantly less than the amount due unless the Qualified Beneficiary is notified of the deficiency and given **31** days to pay the balance.

B. CONTINUATION OF HEALTH COVERAGE NOTICE AND ELECTION PROCEDURES

The following procedures for continuation of benefits under COBRA are hereby adopted by the Plan:

GENERAL NOTICE (INITIAL COBRA NOTICE):

A group health plan subject to the requirements of COBRA must provide written notice to each covered employee and spouse (if applicable) within **90** days after coverage under the Plan commences or the right to continue coverage. (If a Qualifying Event occurs during the first **90** days of coverage under the Plan and before the general notice has been distributed, the Plan may provide only the COBRA election notice, as described below). In lieu of, or in addition to, such written notice, the Plan Administrator is hereby providing the general notice to the employee by delivery of the Summary Plan Description.

The Plan may notify a covered employee and the covered employee's spouse with a single general notice addressed to their joint residence, provided the Plan's latest information indicates that both reside at that address. However, when a spouse's coverage under the Plan begins later than the employee's coverage, a separate general notice must be sent to the spouse within **90** days after the spouse's coverage commences.

NOTE: It is important for the Plan Administrator to be kept informed of the current addresses of all Covered Persons under the Plan who are, or who may become, Qualified Beneficiaries.

EMPLOYER'S NOTICE OF QUALIFYING EVENT AND NOTICES THAT QUALIFIED BENEFICIARIES MUST PROVIDE:

Continuation of health coverage shall be available to an employee and/or his covered dependents upon the occurrence of a Qualifying Event.

To continue health coverage, the Plan Administrator must be notified in writing of a Qualifying Event by:

1. the Employer, within **30** days of the later of: (1) the date of such event or, (2) the date of loss of coverage due to the event, if the Qualifying Event is:
 - a. for a covered dependent, the covered employee's death;
 - b. the covered employee's termination (other than for gross misconduct) or reduction in hours;
 - c. for a covered dependent, the covered employee's entitlement to Medicare.
2. the employee or a Qualified Beneficiary, within **60** days of the later of: (1) the date of such event, (2) the date of loss of coverage due to the event, or (3) the date on which a Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both his obligation to provide notice and the procedures for providing such notice, if the Qualifying Event is:
 - a. for a spouse, divorce or legal separation from a covered employee;
 - b. for a dependent child, loss of dependent status under the Plan; or

- c. the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to continuation coverage with a maximum duration of 18 (or 29) months.

An employee or Qualified Beneficiary who does not provide timely notice to the Employer of one of the above such Qualifying Events may lose his rights under COBRA.

Upon termination of employment or reduction in hours, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date, or at any time during the first **60** days of COBRA continuation coverage, will be entitled to continue coverage for up to **29** months if the Plan Administrator is notified of such disability within **60** days from the later of (and before the end of the **18**-month period): (1) the date of determination, (2) the date on which the Qualifying Event occurs, (3) the date on which the Qualified Beneficiary loses coverage, or (4) the date on which the Qualified Beneficiary is informed through the Plan's Summary Plan Description or general notice of both the obligation to provide the disability notice and the Plan's procedures for providing such notice. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

A Qualified Beneficiary who is disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within **30** days from the later of: (1) the date of final determination that he is no longer disabled, or (2) the date on which the individual is informed through the Plan's Summary Plan Description or general notice of both the responsibility to provide such notice and the Plan's procedures for providing such notice.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – ELECTION NOTICE:

The Plan Administrator must, within **14** days of receiving notice of a Qualifying Event, notify any Qualified Beneficiary of his right to continue coverage under the Plan. Notice to a Qualified Beneficiary who is the employee's spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

ELECTION PROCEDURES:

A Qualified Beneficiary must elect Continuation of Health Coverage within **60** days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A new spouse, a newborn child, or a child placed with a Qualified Beneficiary for adoption during a period of COBRA continuation coverage may be added to the Plan according to the enrollment requirements for dependent coverage under the "**ELIGIBILITY REQUIREMENTS**" section of the Plan. A Qualified Beneficiary may also add new dependents during an open enrollment period held once each year at a time and in accordance with the procedures established by the Plan Administrator.

Any election by an employee or his spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within **45** days of the date of such election, pay all required contributions to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a **30-day** grace period. If the initial contribution payment is not made within **45** days of the date of the election, COBRA coverage will not take effect. If future contribution payments are not made within the allotted **30-day** grace period, COBRA coverage will be terminated retroactively back to the end of the month in which the last full contribution payment was made.

Except as provided herein, if the initial coverage election and required contribution payments are made in a timely manner, as described in this section, coverage under the Plan will be reinstated retroactively back to the date of the Qualifying Event.

If a Qualified Beneficiary waives COBRA coverage, he may revoke the waiver at any time during the election period. The Qualified Beneficiary would be eligible for continuation of coverage prospectively from the date that the waiver is revoked, if all other requirements, such as timely contribution payments, are met.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – NOTICE OF UNAVAILABILITY OF CONTINUATION COVERAGE:

The Plan Administrator must provide a notice of unavailability to an individual within **14** days after receiving a request for continuation coverage if the Plan determines that such individual is not entitled to continuation coverage. The notice must include an explanation as to why the individual is not entitled to COBRA. This notice must be provided regardless of the basis of the denial and regardless of whether it involves a first or second Qualifying Event or a request for disability extension.

PLAN ADMINISTRATOR'S NOTICE OBLIGATION – EARLY TERMINATION NOTICE:

The Plan Administrator must provide a notice to Qualified Beneficiaries when COBRA terminates earlier than the maximum period of COBRA applicable to the Qualifying Event as soon as practicable following its determination that continuation coverage shall terminate. This notice must contain the reason that continuation coverage has terminated earlier than the maximum period triggered by the Qualifying Event, the date of termination of continuation coverage, and any rights the Qualified Beneficiary may have under the Plan or under applicable law to elect alternative group or individual coverage (such as a conversion right).

TRADE ACT OF 2002:

The Plan shall fully comply with the Trade Act of 2002 as the Act applies to employee welfare benefit plans.

C. PREMIUMS FOR COBRA COVERAGE

The Qualified Beneficiary may be required to pay premiums for any period of COBRA coverage equal to 102% of the applicable premium, in accordance with applicable law. However, any Qualified Beneficiary (including all family members of such individual who are Qualified Beneficiaries) who is entitled to the disability extension (as specified above), may be required to

pay premiums equal to 150% of the applicable premium for the coverage period following the initial 18-month period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

The cost of COBRA coverage may be subject to future increases during the period it remains in effect.

D. TERMINATION OF COVERAGE

COBRA continuation coverage will end upon the earliest of the following to occur:

1. if an employee is terminated or has his hours reduced:
 - a. **18** months from the date of the Qualifying Event; or
 - b. **29** months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first **60** days of COBRA continuation coverage and provides notice as required by law (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).
2. the day, after the **18** month continuation period, which begins more than **31** days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to **29** months, is determined to be no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
3. for a covered dependent, **36** months from the date of the Qualifying Event if the Qualifying Event is:
 - a. the covered employee's death;
 - b. the covered employee's entitlement to Medicare;
 - c. a spouse's divorce or legal separation from a covered employee; or
 - d. a dependent child's loss of dependent status under the Plan.
4. **APPLIES TO ONLY THOSE COBRA QUALIFIED BENEFICIARIES EFFECTIVE PRIOR TO 7/1/04:** if any of the Qualifying Events listed in 3. occurs during the **18**-month period (or **29**-month period if there is a disability extension) after the date of the initial Qualifying Event listed in 1., coverage terminates **36** months after the date of the initial Qualifying Event listed in 1.
APPLIES TO ONLY THOSE COBRA QUALIFIED BENEFICIARIES EFFECTIVE ON OR AFTER 7/1/04: if any of the Qualifying Events listed in 3. (with the exception of "the covered employee's entitlement to Medicare") occurs during the **18**-month period (or **29**-month period if there is a disability extension) that follows the date of the initial Qualifying Event listed in 1., coverage terminates **36** months after the date of the initial Qualifying Event listed in 1. If the covered employee's entitlement to Medicare occurs during the **18**-month period (or **29**-month period if there is a disability extension) that follows the date of the initial Qualifying Event listed in 1., coverage terminates **18** months (or **29**

months if there is a disability extension) after the date of the initial Qualifying Event listed in 1.

1. the date on which the Employer ceases to provide any group health plan coverage to any employee.
2. the date of the Qualifying Event if the Qualified Beneficiary fails to make the initial contribution payment within **45** days of the date of the election.
3. the last day of the month in which the last contribution payment was made if the Qualified Beneficiary fails to make future contribution payments within the allotted **31**-day grace period as described in this section.
4. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary.
5. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare.
6. the date this Plan terminates.

VIII. CLAIMS PROVISIONS

A. CLAIM DETERMINATIONS MADE IN ACCORDANCE WITH PLAN DOCUMENTS

The Plan's claims procedures shall include administrative safeguards and processes designed to ensure and verify that benefit claims determinations are made in accordance with governing Plan documents and, where appropriate, that the Plan's provisions have been applied consistently with respect to similarly situated claimants.

B. CLAIM DEFINED

A "claim" is any request made by a claimant or a claimant's representative for benefits under the Plan that complies with the Plan's reasonable procedure for filing claims. A request for benefits includes a request for coverage determination, pre-authorization or approval of a plan benefit, or a utilization review determination in accordance with the terms of the Plan.

Requests for eligibility determinations are not claims for benefits. However, when a claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant has the right to appeal that determination in accordance with the Plan's claims procedures.

C. CLAIM FILING

The Plan Administrator (or Employer) will furnish to the Covered Person, upon request, forms for filing proof of loss. If such forms are not furnished within **15** days after receipt of notice of a claim, any written form that includes information indicating the occurrence, character, and extent of the loss for which a claim is made may be used to submit a proof of loss. A claim form may be required to be submitted at least once per year for each person who incurs covered expense.

The completed claim form and the original bills for expenses incurred must be submitted to the Claims Administrator within **1 year** after the date the loss occurred or commenced.

When a Covered Person's coverage terminates for any reason, written proof of claim must be given to the Claims Administrator within **90** days of the date of termination of coverage, if the Plan remains in force. Upon termination of the Plan, final claims must be received within 31 days of termination.

D. LIMITATION OF LIABILITY

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim if the proof of loss for such claim was not submitted within the period provided in "**Claim Filing**" above, except in the case of legal incapacity of the Covered Person.

E. URGENT CARE CLAIM RULES

For urgent care claims, the Claims Administrator will notify the claimant of its determination, whether adverse or not, as soon as possible but not later than 72 hours from receipt of the claim at the initial benefit determination level (and within not later than 72 hours at the appeal level upon review of an adverse benefit determination).

Notice of a benefit grant or denial may be provided orally, provided that a written or electronic notice of benefit grants or denials is sent to the claimant not later than three (3) days after the oral notification.

The term “urgent care claim” means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except as provided in the next sentence, whether a claim is an urgent care claim is to be determined by a person acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is an urgent care claim involving urgent care shall be treated as an urgent care claim for purposes of these provisions.

F. CONCURRENT CARE DECISION RULES

For concurrent care decisions, the Claims Administrator will notify the claimant of its decision to terminate or reduce benefits that have already been approved that may disrupt an ongoing course of treatment to be provided over a period of time or a number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that decision before the benefit is reduced or terminated.

Any urgent care claim involving ongoing care (requesting to extend a course of treatment beyond the initially prescribed time period or number of treatments) must be decided within 24 hours provided that the claim is made at least 24 hours prior to the expiration of the initially prescribed period.

G. PRE-SERVICE CLAIM RULES

For pre-service claims, generally, the Claims Administrator must notify the claimant of its determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances but not later than 15 days from receipt of the claim at the initial level (or within 30 days at the appeal level). One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit grants or denials must be provided in the case of pre-service claims.

A “pre-service” claim is any request for approval of a benefit to which receipt is conditioned by the Plan, in whole or in part, upon advance approval of obtaining medical care (for example, pre-approval under utilization review or for a prior authorization).

H. POST-SERVICE CLAIM RULES

For post-service claims, generally, the Claims Administrator will notify the claimant of its adverse determination within a reasonable period of time, but not later than 30 days from receipt of the claim at the initial level (or within 60 days at the appeal level). One 15-day extension of time is available if the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit necessary information, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Written or electronic notice of benefit denials must be provided in the case of post-service claims.

I. INCOMPLETE CLAIMS NOTICE DISCLOSURE REQUIREMENT

The Claims Administrator will determine whether a filed claim is incomplete. A claim is filed in accordance with reasonable filing procedures of the Plan, without regard to whether all information necessary to decide the claim accompanies the filing.

The Claims Administrator must notify the claimant or claimant's representative of failure to follow proper claims filing procedures. With respect to urgent care claims, the Claims Administrator will provide incomplete claims notice within 24 hours of receipt of the claim. With respect to pre-service claims, notice of incomplete claims will be provided within five (5) days. Notification by the Claims Administrator may be oral, unless written notification is requested by the claimant or claimant's authorized representative.

J. MANNER AND CONTENT OF BENEFIT DETERMINATION

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. the specific reason(s) for the adverse determination;
2. references to the specific plan provisions upon which the determination is based;
3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
5. if the Plan utilizes a specific internal rule, guideline, protocol, or other similar criterion in making the determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon and that a copy of such rule, guideline, protocol or similar criterion will be provided free of charge to the claimant upon request;
6. if the determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

7. in the case of a determination concerning an urgent care claim, a description of the expedited review process applicable to such claims.

K. APPEAL OF DENIED CLAIM AND REVIEW PROCEDURE

A claimant will be notified in writing by the Claims Administrator if a claim, or any part of a claim, is denied. If a claimant does not agree with the reason for the denial (including a denial of benefits based on a determination of a claimant's eligibility to participate in the Plan), he may file a written appeal within **180** days after the receipt of the original claim determination. The request should state the basis for the disagreement along with any data, questions, or comments he thinks are appropriate, and should be sent to the office of the Claims Administrator. An appropriate named fiduciary who is neither the person who made the initial determination, nor the subordinate of such person, shall conduct a full and fair review of the determination. The review shall not defer to the initial determination, and it shall take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was previously submitted or considered in the initial determination. In addition, in deciding an appeal of any determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional, who was neither the person who was consulted in connection with the initial benefit determination, nor the subordinate of such person, and who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Claims Administrator will disclose to the claimant the names of any medical professionals consulted as part of the claims process.

In the case of the review of urgent care determination, a request for an expedited appeal of a claim denial may be submitted orally or in writing by the claimant; and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

The claimant will be notified of the results of the review by the Claims Administrator. On pre-service and post-service claim denials, the Plan provides a single level of mandatory appeal. The single level of appeal will be resolved within 30 days of the date the appeal was received for pre-service claims, and 60 days of the date the claim was received for post-service claims.

L. MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

The Claims Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination on review. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. the specific reason(s) for the adverse determination on review;
2. reference to the specific plan provisions upon which the review is based;
3. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his claim for benefits;

4. a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under section 502(a) of ERISA;
5. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. if the adverse benefit determination on review is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. the following statement: "Other voluntary alternative dispute resolution methods, such as mediation, may be available. You may seek additional information by contacting your local U.S. Department of Labor office and your State insurance regulatory agency."

M. AUTHORIZED REPRESENTATIVES

A claimant's authorized representative, including a health care provider, is not precluded from acting on behalf of the claimant in pursuing a benefit claim or appeal. The Claims Administrator shall recognize a health care professional with knowledge of a claimant's medical condition as the claimant's representative in connection with an urgent care claim. The Claims Administrator may establish reasonable procedures for determining whether a person has been authorized to act on behalf of a claimant.

N. PAYMENT OF BENEFITS

All benefits under the Plan are payable to the covered employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of incapacity of a covered employee and in the absence of written evidence to the Plan of the qualification of a guardian (or person acting under durable power of attorney) for the covered employee's estate, the Plan may, at its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of such employee. In the event of death, the personal representative of the estate will act on behalf of the covered employee.

Benefits for expenses covered under the Plan may be assigned by a covered employee to the individual or institution rendering the services for which the expenses were incurred. No such assignment will bind the Plan Administrator unless it is in writing and unless it has been received and accepted by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered employee and the assignee, has been received by the Claims Administrator before the proof of loss is submitted. Payment of benefits will be made by the Plan in accordance with any assignment of rights made by or on behalf of a Covered Person if required by a Qualified Medical Child Support Order (QMCSO). The Plan will not take Medicaid eligibility into account and will pay benefits in accordance with any assignment of rights under a state Medicaid law.

O. DISCHARGE OF LIABILITY

Any payment made in accordance with the provisions of this section shall fully discharge the liability of the Plan Administrator to the extent of such payment.

P. RECOVERY OF OVERPAYMENTS

If an overpayment is made under this Plan, the Plan Administrator reserves the right to determine and exercise one or all of the following options that it deems necessary to recover the overpayment to the Plan. The Plan Administrator may:

- request the overpayment from any Covered Person to whom such overpayment was made;
- request the overpayment from any provider to whom such overpayment was made; and/or
- deduct the overpayment of benefits from subsequent benefits payable to the Covered Person.

Each Covered Person is deemed, through participation in the Plan, to authorize recovery of overpayments as described above.

Q. LEGAL ACTIONS

Proper written proof of loss must be filed in accordance with the requirements of the Plan. If timely decisions or other ERISA claims procedures regulations fail to be made or followed, a claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under section 502(a) of the Act to enforce their rights.

IX. IMPORTANT INFORMATION

A. GENERAL INFORMATION

Type of Plan: Group Dental Plan

Type of Plan Administration: This benefit plan provides reimbursement for certain dental expenses.

Plan Name: Schreiner University Dental Plan

Plan Number: 502

Employer Tax Identification Number: 74-1193459

Effective Date: The original effective date of the self-funded Plan is June 1, 1999. The restated effective date of the Plan as set forth in the most current Plan Document is June 1, 2008. The effective date of administration by the Claims Administrator is July 1, 2004.

End of Plan Year: June 30

Plan Sponsor: Schreiner University

Plan Administrator/Agent for Service of Legal Process:

Schreiner University
CMB 6206, 2100 Memorial Blvd.
Kerrville, TX 78028
830-792-7375

Fiduciary for Adverse Benefit Determinations: Schreiner University

Claims Administrator: The Claims Administrator provides claims administration for the Plan and does not insure or otherwise guarantee benefits. The Claims Administrator is:

Fiserv Health Plan Administrators, Inc.
Post Office Box 690450
San Antonio, Texas 78269-0450
(800) 218-1004

Case Management Company: Fiserv Health Plan Administrators, Inc.

Trustees: Individuals appointed by the Company to administer the Plan, and Trust if established.

B. FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Plan is funded by contributions from the Employer and/or the persons covered hereunder. From time to time, the Plan Sponsor will evaluate the costs of the Plan and determine the amount to be contributed by the Employer, as well as the amount to be contributed by each Employee, if any.

Contributions to the Plan shall be placed in a designated account administered by the Plan Sponsor. The contributions will be applied to provide benefits for eligible expenses under the Plan.

The benefits described in this Plan are partially self-funded. Excess Loss Coverage (Stop Loss Insurance or Reinsurance) has been obtained.

C. COST SHARING

Employee and/or dependent coverage may be conditioned upon whether required premium contributions have been made. Premium contributions, if required, are established by the Plan Administrator in its sole discretion and are subject to change from time to time. A current summary of these premium amounts may be obtained from the Employer at any time upon request. Additional cost-sharing provisions for which the Covered Person may be responsible include, but are not limited to, deductibles, copays, out-of-pocket expenses, penalties for non-compliance with the Plan's certification requirements, and non-covered expenses.

D. CHANGES TO PLAN/TERMINATION OF PLAN

The Plan may be changed and/or benefits may be reduced or eliminated by execution of an amendment to the Plan by the Plan Sponsor. The Plan Sponsor shall have the right to amend the Plan, at any time and from time to time, to any extent deemed advisable in its discretion, without prior notice to or consent of any Covered Person or of any person entitled to receive payment of benefits under the Plan. Any such amendment shall be set forth in a written instrument that is designated as an amendment to the Plan and executed by the Plan Sponsor.

All changes to the Plan shall become effective as of a date established by the Plan Sponsor, and thereupon all Covered Persons, whether or not they became Covered Persons prior to such amendment, shall be bound thereby. However, no amendment shall be effective with respect to any covered expense incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change.

The Plan shall continue in full force and effect unless and until the Plan Sponsor terminates the Plan. Although the Plan Sponsor has the intention and expectation that the Plan will be maintained indefinitely, the Plan Sponsor is not and shall not be under any obligation or liability whatsoever to continue or maintain the Plan for any given length of time. The Plan Sponsor, in its sole and absolute discretion, may discontinue or terminate the Plan at any time by providing written notice to the covered employees. Such termination will become effective on the date set forth in such written notice.

The **Director of Human Resources, Vice President of Administration and Finance, or President** is authorized to amend, modify or terminate this Plan.

E. CIRCUMSTANCES RESULTING IN LOSS OR REDUCTION OF BENEFITS

There are circumstances that may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of benefits that a Covered Person might reasonably expect the Plan to provide. These circumstances include, but are **not** limited to:

- subrogation, reimbursement and third party recovery rights of the Plan;
- coordination of benefits when a Covered Person is enrolled in more than one plan and this Plan is not the primary plan;
- possible reductions when private hospital rooms are used and for certain multiple surgical procedures;
- reductions due to charges that exceed usual and customary allowances;
- reductions or denials due to services that are not generally accepted as appropriate, and/or which are not medically necessary, and/or which are considered as overutilization;
- treatment, services and supplies that are excluded from coverage by the Plan, whether or not medically necessary;
- non-compliance with the Plan's certification requirements;
- non-compliance with the Plan's claims filing deadline.

These provisions are described in greater detail throughout this document.

F. OBTAINING COVERAGE INFORMATION

A Covered Person may obtain information at no cost on whether, and under what circumstances, existing and/or new drugs, tests, devices, procedures and other services are covered, as well as obtain specific benefit information, by contacting the Customer Service Department of the Claims Administrator.

G. CHOICE OF PHYSICIAN

A Covered Person shall have **free choice of any physician** as defined in this Plan. The Plan Administrator shall not in any way disturb the physician-patient relationship. Physicians and other health care providers are not agents of the Employer, the Plan Administrator, or the Claims Administrator. The actual provision of dental and other services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending physician or other health care provider.

H. PLAN ADMINISTRATOR'S DUTY TO ISSUE CERTIFICATES OF CREDITABLE COVERAGE

The Plan Administrator shall issue certificates of creditable coverage to a Covered Person: (a) whose coverage terminates; (b) when the individual's coverage ceases due to the operation of a lifetime limit on all benefits (coverage is considered to cease on the earliest date that a claim is denied due to the operation of the lifetime limit); and (c) to individuals upon their written request while the individual is covered under the Plan and within 24 months of the date of coverage termination, as required by Federal law. Written procedures for requesting certificates of creditable coverage may be obtained from the Plan Administrator.

I. PLAN ADMINISTRATOR'S DUTY TO ISSUE NOTICES UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Plan Administrator shall provide each eligible employee a notice at enrollment and to each covered employee annually thereafter describing the Plan's benefits for a person who has a

mastectomy with respect to: reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prosthesis and physical complications in all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

J. EXAMINATION

The Claims Administrator shall have the right and opportunity to have a Covered Person examined whose injury or illness is the basis of a claim hereunder when, and as often as it may reasonably require, during pendency of a claim hereunder, and also the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

K. WRITTEN NOTICE

Any written notice required under the Plan shall be deemed received by a covered employee if sent by regular mail, postage prepaid, to the last address of such covered employee on the records of the Employer.

L. CLERICAL ERROR/DELAY

Clerical error made on the records of the Employer and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. The effective dates of coverage shall be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made. Errors cannot provide a benefit to which a Covered Person is not otherwise entitled.

M. ACCEPTANCE/COOPERATION

Accepting benefits under the Plan means that the Covered Person has accepted its terms and is obligated to cooperate with the Plan Sponsor in doing what the Plan Sponsor may ask to help protect the Plan's rights and carry out its provisions.

The Plan Sponsor has discretionary authority to determine eligibility for and the amount of benefits under this Plan.

Failure to enforce a provision does not waive other provisions or the enforcement of that provision in other instances. Enforceability of any single provision shall not affect enforceability of other provisions.

N. NOT A CONTRACT OF EMPLOYMENT

Nothing contained in this Plan shall be construed as:

- a contract of employment between an Employer and any employee;
- a right of any employee to be continued in the employment of an Employer;
- consideration or inducement for employment with an Employer;
- a condition of employment between an Employer and any employee; or

- a limitation of the right of an Employer to discharge any employee, with or without cause, at any time.

All employees shall be subject to discharge to the same extent as if the Plan had never been adopted.

X. HIPAA PRIVACY RULE

Effective April 14, 2004, the **Schreiner University Dental Plan** (hereinafter referred to as the "Plan") conforms with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the "HIPAA Privacy Rule" and § 164.504(f) is referred to as "the '504' provisions") by establishing the extent to which the Plan Sponsor will receive, use, and/or disclose Protected Health Information (hereinafter referred to as "PHI").

A. PLAN'S DESIGNATION OF PERSON/ENTITY TO ACT ON ITS BEHALF

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Plan Sponsor to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts; accepting certification from the Plan Sponsor).

B. THE PLAN'S DISCLOSURE OF PHI TO THE PLAN SPONSOR/REQUIRED CERTIFICATION OF COMPLIANCE BY PLAN SPONSOR

Except as provided below with respect to the Plan's disclosure of summary health information, the Plan will (a) disclose PHI to the Plan Sponsor, or (b) provide for or permit the disclosure of PHI to the Plan Sponsor by a health insurance issuer or HMO with respect to the Plan, **only if** the Plan has received a certification (signed on behalf of the Plan Sponsor) that:

1. the Plan Document has been amended to establish the permitted and required uses and disclosures of such information by the Plan Sponsor, consistent with the "504" provisions;
2. the Plan Document has been amended to incorporate the Plan provisions set forth in this section; and
3. the Plan Sponsor agrees to comply with the Plan provisions as modified by this section.

C. PERMITTED DISCLOSURE OF INDIVIDUALS' PHI TO THE PLAN SPONSOR

The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals' PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the PHI of the Plan's individuals by the Plan's business associate, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this section and in the "504" provisions.

The Plan (and any business associate acting on behalf of the Plan), may not, and may not permit the health insurance issuer or HMO to, disclose individuals' PHI to the Plan Sponsor for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' PHI other than as described in the Plan Document and permitted by the "504" provisions.

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

The Plan Sponsor will not use or disclose individuals' PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan Sponsor becomes aware.

D. DISCLOSURE OF INDIVIDUALS' PHI/DISCLOSURE BY THE PLAN SPONSOR

The Plan Sponsor will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. § 164.524.

The Plan Sponsor will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI in accordance with 45 C.F.R. § 164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' PHI that it must account for in accordance with 45 C.F.R. § 164.528.

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

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

The Plan Sponsor will ensure that the required adequate separation, described elsewhere in this section, is established and maintained.

E. DISCLOSURES OF SUMMARY HEALTH INFORMATION AND ENROLLMENT AND DISENROLLMENT INFORMATION TO THE PLAN SPONSOR

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan Sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan Sponsor requests the summary health information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- modifying, amending, or terminating the Plan.

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

F. REQUIRED SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR

In accordance with the “504” provisions, following is a description of the employees, classes of employees, or workforce members under the control of the Plan Sponsor who may be given access to individuals’ PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan.

1. Director of Human Resources;
2. Human Resources Coordinator;

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

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

XI. HIPAA SECURITY STANDARDS

This section is intended to bring the Schreiner University Dental Plan (hereinafter “Plan”) into compliance with the requirements of 45 C.F.R. § 164.314(b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the “HIPAA Security Standards”) by establishing the Plan Sponsor’s obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on April 20, 2006.

A. DEFINITIONS

1. **“Electronic Protected Health Information”** has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
2. **“Plan”** means the Schreiner University Dental Plan.
3. **“Plan Document”** means the group health plan’s governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Plan Document of the Schreiner University Dental Plan.
4. **“Plan Sponsor”** means the entity as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan Sponsor is Schreiner University.
5. **“Security Incidents”** has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

B. PLAN SPONSOR OBLIGATIONS

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

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware

as described below:

- a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
- b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan's request. NOTE: The Plan Sponsor shall have a reasonable period of time after learning of a security incident to report any successful attempt to the Plan, but can aggregate the data relating to unsuccessful attempts and report that information to the Plan on a less frequent basis.

XII. ERISA RIGHTS

A. RECEIVING INFORMATION ABOUT THE PLAN AND ITS BENEFITS

As a participant in the **SCHREINER UNIVERSITY DENTAL PLAN**, an employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report (if applicable). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report (in the event that the Plan has to file such a report).
- receive a summary of material reduction in covered services or benefits provided under the Plan within **60** days after the adoption of the changes (unless summaries of changes to the Plan are provided at regular intervals of **90** days).

B. CONTINUING GROUP HEALTH PLAN COVERAGE

A participant shall be entitled to continue health care coverage for himself, his spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The participant or his dependents may have to pay for such coverage. Participants should review this Summary Plan Description and the documents governing the Plan for the rules governing COBRA continuation coverage rights.

A participant shall also be entitled to reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the group health plan if he has creditable coverage from another plan. The participant should be provided a certificate of creditable coverage, free of charge, from his group health plan or health insurance issuer when his coverage is lost, if he becomes entitled to elect COBRA continuation coverage, or when his COBRA continuation coverage ceases, provided that he requests the certificate before losing coverage or up to 24 months after losing coverage. Without evidence of creditable coverage, a participant and/or his beneficiaries may be subject to a pre-existing condition exclusion for 12 months (up to 18 months for late enrollees) after the participant's or beneficiary's enrollment date for coverage.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

D. ENFORCING RIGHTS AS A PARTICIPANT

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

Under ERISA, there are steps a participant can take to enforce the above rights. For instance, if the participant requests a copy of Plan Documents or the latest annual report from the Plan and does not receive the materials within **30** days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the participant up to **\$110.00** a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a participant has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a state or Federal court, provided he has exhausted the administrative remedies available under the Plan. In addition, if a participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if a participant is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in Federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person he has sued to pay these costs and fees. If the participant loses, the court may order him to pay these costs and fees, for example, if the court finds his claim is frivolous.

E. ASSISTANCE WITH QUESTIONS

If the participant has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, or if he needs assistance in obtaining documents from the Plan Administrator, he should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. A participant may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XIII. PLAN DOCUMENT INFORMATION

SCHREINER UNIVERSITY desires to amend and restate its Dental Plan that provides health and certain other benefits for its employees and their eligible dependents. Therefore, it has amended and restated the **SCHREINER UNIVERSITY DENTAL PLAN**, hereinafter referred to as the “Plan,” as set forth in this document, hereinafter referred to as the “Plan Document.”

A. PURPOSE

The purpose of this Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of all or a portion of covered health expenses.

B. STATEMENT OF PLAN

This Plan, any exhibits or appendices hereto, and the individual enrollment applications of the persons covered hereunder shall constitute the entire Plan Document.

C. CLASSIFICATION OF COVERED PERSONS AND SCHEDULE OF DENTAL BENEFITS

The Schedule of Dental Benefits and classification of Covered Persons for all employees and their dependents eligible for benefits under this Plan are as set forth in this Plan Document.

D. SUMMARY PLAN DESCRIPTION

The Plan Sponsor will issue to each covered employee under this Plan a Summary Plan Description that describes the benefits available under the Plan, to whom benefits are payable, and the provisions of this Plan principally affecting Covered Persons. Individuals covered under COBRA may receive a Summary Plan Description upon request from the Plan Sponsor. This Plan Document may also function as the Summary Plan Description.

E. CONFORMITY WITH THE LAW

Any provisions of the Plan which, on or after its effective date, are in conflict with any applicable law, are hereby amended to conform to the minimum requirements of such laws.

F. TERMINATION OR MODIFICATION

The Plan Sponsor reserves the right to amend, modify or terminate, without advance notice, all or any part of this Plan at any time, without any liability whatsoever for such termination, and to make any other changes that it deems necessary or appropriate in its sole discretion; provided, however, no amendment, modification, or termination shall adversely affect the right of a Covered Person to receive reimbursement for dental expenses incurred prior to the date of such amendment, modification, or termination.

G. NAMED FIDUCIARY, PLAN SPONSOR, AND PROCEDURE FOR ALLOCATION RESPONSIBILITIES

The named Fiduciary and Plan Sponsor is **SCHREINER UNIVERSITY** and it shall have those powers, duties, responsibilities and obligations as are granted under the Plan and applicable law. The Plan Sponsor, in its discretion, may delegate responsibilities for the operation and administration of the Plan. The Plan Sponsor shall have the discretionary authority to amend or terminate the Plan and to construe and construct the terms and provisions of the Plan. The Plan Sponsor shall determine its policies, contract with insurers, and appoint and remove insurers and/or agents, fix their compensation (if any), and exercise general administrative authority over them. The Plan Sponsor has the sole authority and responsibility to review and make final decisions, in its discretion, on all benefits.

H. PLAN ADMINISTRATION

The Plan provides welfare benefits as defined in ERISA. The benefits are partially self-funded. The Plan may be administered by a Claims Administrator or by the Employer. Cost containment features may be included in the Plan. The Plan Year may be independent of the Contract Year for insurance purposes or the Calendar Year for determining benefits.

Excess Loss Carriers and Claims Administrators may be changed by the Plan Sponsor in its discretion. The Plan Sponsor may also change, add, and/or delete benefits by amendment to the Plan at any time in its discretion.

Plan assets may be governed by a trust. The trust is usually, but not necessarily, a tax-exempt trust, IRC 501(c)(9). Excess Loss Coverage may be obtained. With a self-funded arrangement, the Plan Sponsor has such final responsibility for Plan decisions.

Only the Plan Sponsor has ERISA fiduciary responsibility. The Claims Administrator does not have fiduciary responsibility under ERISA.

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This Plan Document SUPERSEDES ALL OTHER PLAN DOCUMENTS AND ISSUED AMENDMENTS and shall be the sole document used in determining benefits for which Covered Persons are eligible and may be amended from time to time by the Plan Sponsor to reflect changes in benefits or eligibility requirements. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation. Any change so made shall be binding on each Covered Person and any other individual(s) referred to in the Plan Document.

SCHREINER UNIVERSITY DENTAL PLAN

RESTATEMENT OF PLAN

Employer hereby amends and restates by this Plan Document an employee welfare benefit plan. It is intended that this Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that this Plan Document shall conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as the act applies to employee welfare benefit plans. If any portion of the Plan Document, now or in the future, conflicts with ERISA or Federal regulations, such regulations will govern.

By

Date

Title

Witness

SCHREINER UNIVERSITY

Plan Sponsor