

LEGAL AID SOCIETY OF SAN DIEGO, INC.

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

DENTAL BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE
"LEGAL AID SOCIETY OF SAN DIEGO, INC. DENTAL BENEFITS PLAN"

EFFECTIVE: JULY 1, 2021
UPDATED: JULY 1, 2022

Contract Administrator:



Employee Benefits Administration & Management Corporation
Mailing Address: 18002 Cowan Irvine, CA 92614
Phone: (800) 249-8440

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ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Legal Aid Society of San Diego, Inc. (the "Company" or the "Plan Sponsor") as of July 1, 2021.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Legal Aid Society of San Diego, Inc.

By: _____

Name: _____

Title: _____

Date: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a Non-occupational Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for dental charges. The Plan Document is maintained by Legal Aid Society of San Diego, Inc. and may be inspected at any time during normal working hours by any Participant.

Name of Plan: **Legal Aid Society of San Diego, Inc. Dental Benefits Plan**

Plan Sponsor / Plan Administrator: **Legal Aid Society of San Diego, Inc.**
Address: 110 South Euclid Avenue
San Diego, CA 92114

Business Phone Number: (877) 534-2524

Participating Employer(s): **Legal Aid Society of San Diego, Inc.**

Plan Sponsor ID Number (EIN): **95-1869806**

Plan Number: **501**

Plan Year: **July 1st through June 30th**

Named Fiduciary(ies) / Title(s): **Legal Aid Society of San Diego, Inc.**
Address: 110 South Euclid Avenue
San Diego, CA 92114

(See also definition of "Fiduciary")

Designated Legal Agent: **Legal Aid Society of San Diego, Inc.**
Address: 110 South Euclid Avenue
San Diego, CA 92114

(Legal process may be served upon the Plan Sponsor or a Fiduciary)

Type of Plan: **This is an employee welfare benefit plan providing group health benefits**

Plan Benefits Described Herein: **Self-Funded Dental Benefits**

Type of Administration: **Contract Administration** (see "Administrative Provisions" for additional information)

Applicable Collective Bargaining Agreement(s) **None**

Contract Administrator: **EBA&M
Employee Benefits Administration
& Management Corporation**

Mailing Address: 18002 Cowan
Irvine, CA 92614

Phone: (800) 249-8440

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION, *continued*

The Plan shall take effect for each Participating Employer on the Effective Date unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Applicable Law

This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Persons' rights; and to determine all questions of fact and law arising under the Plan.

IMPORTANT INFORMATION

This is a self-funded benefit coming within the purview of the Employee Retirement Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

COBRA NOTICE REQUIREMENTS

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired employees. The procedures are also included herein and are located immediately following the **COBRA Continuation Coverage** section (see the **COBRA Notice Requirements for Plan Participants** section). Please review that section for additional details or contact the Plan Administrator for the most current notice procedures.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become COBRA Qualified Beneficiaries.

KEEP THE PLAN INFORMED OF CHANGES

It is the responsibility of each Covered Person to assure that the Plan Administrator has current and accurate information regarding their eligibility, the eligibility of any qualified Dependents, and whether or not a Covered Person is enrolled in another health / dental plan. Failure to notify the Plan Administrator in a timely manner can jeopardize eligibility for coverage and can even lead to termination of coverage and loss of eligibility for possible extended coverage (COBRA). See the Eligibility and Effective Dates, Termination of Coverage, Extension of Coverage Provisions and COBRA Continuation Coverage sections for more information.

To notify the Plan Administrator of changes, contact the Legal Aid Society of San Diego, Inc. Personnel Department for the necessary form. Notifications must be made in writing and will require the Employee's name, the name(s) of any eligible Dependents affected by the change, a description of the change and the effective date of the change.

Some situations that would require notification to the Plan Administrator/Personnel Department include, but are not limited to:

Employee acquires a new Dependent – by marriage, birth, adoption, etc. **(must enroll within 31 days)**.

Dependent no longer meets eligibility criteria – legal separation/divorce, Dependent child turns age 26, Dependent begins active military duty, etc. **(must notify within 60 days)**.

Covered Person obtains coverage under another health / dental plan **(must notify immediately)**.

Contact the Plan Administrator / Personnel Department for more information.

DENTAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

THIS PLAN DOES NOT UTILIZE A NETWORK OF DENTAL PROVIDERS. COVERED MEMBERS CAN USE ANY DENTIST OF THEIR CHOICE.

SCHEDULE OF DENTAL BENEFITS

PLAN MAXIMUMS	
Plan Year Maximum Benefit	\$2,400
Plan benefits for each Covered Person will not exceed the maximums shown above. Dental benefits include coverage of Implants, Inlays, Onlays, and Cosmetic services.	
ELIGIBLE DENTAL EXPENSES	Covered Person Pays Plan Pays
Preventive Services	-0- 100%
Basic Services	-0- 100%
Major Services	-0- 100%
Orthodontia	-0- 100%

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are dental services and supplies that are listed below and that are: (1) incurred while a person is covered hereunder, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision, Orthodontist, or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

- for an appliance or modification of an appliance, on the date the final impression is taken;
- for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;
- for root canal therapy, on the date the pulp chamber is opened; or
- for any other service, on the date the service is rendered.

NOTE: Dental Discount Programs are eligible for reimbursement under this Plan.

PREVENTIVE SERVICES

Exams & Cleanings, Routine - Routine oral examinations and routine cleaning and polishing of the teeth.

Fluoride - Topical application of stannous or sodium fluoride.

Pathology - Laboratory services required for dental procedures.

Prophylaxis - see "Exams & Cleanings, Routine"

Sealants - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

Study Models - Diagnostic casts for the purpose of diagnosis and preparation of restorations.

X-rays - Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray, and routine bitewing X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Crown Buildup - Post and core when necessary for the placement of a crown.

Fillings, Non-Precious - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

Injections - Injection of antibiotic drugs.

Palliatives - Emergency treatment for the relief of dental pain.

Stainless Steel Crowns

Visits, Non-Routine - Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure. Professional visits after hours.

MAJOR SERVICES

Cosmetic Dentistry - Treatment rendered for cosmetic purposes

ELIGIBLE DENTAL EXPENSES, *continued*

Charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or charges for a tooth-colored restoration

Crowns – Initial placement of a gold, porcelain or composite crown restoration

Replacement of a crown.

See "Cosmetic Dentistry" veneer or facing (i.e., "tooth-colored") restorations. Coverage includes crowns placed for periodontal splinting.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Extraction - see "Oral Surgery"

Implants - Implants (materials implanted into or on bone or soft tissue to support a crown or prosthetic, including services and supplies necessary for their installation), or the removal of implants.

Inlays, Onlays & Gold Fillings - Initial placement of an inlay, onlay or gold filling

Replacement of an inlay, onlay or gold restoration.

See "Cosmetic Dentistry" for "tooth-colored" restorations.

Oral Surgery - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontia - Treatment of the gums and tissues of the mouth, including periodontal scaling and root planing, subgingival curettage, gingival and osseous surgery.

Prosthetics - Initial placement of a full or partial denture or bridge to replace one or more natural teeth that are extracted while the person is covered hereunder.

Replacement of or addition of teeth to an existing full or partial denture or bridge.

Repairs & Adjustments - Repair or re-cementing of a crown, inlay, bridge or denture or the relining of a denture. Prosthetic adjustments.

ORTHODONTIA

Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth, including:

initial consultation, models, X-rays and other diagnostic services;

initial banding or placement of orthodontic appliance(s);

periodic adjustments; and

retainers.

Payments will be divided into equal installments, based upon the estimated number of months of treatment, and will be paid over the treatment period as proof of continuing treatment is submitted. The maximum benefit for orthodontia services is shown in the "Plan Maximums" in the **Dental Benefit Summary**. This maximum applies to the entire period(s) a person is covered hereunder.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Non-Professional Care - Services rendered by someone other than:

- a dentist (DDS or DMD);
- an orthodontist;
- a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
- a Physician furnishing dental services for which he is licensed.

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the person's effective date of coverage, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to thirty (30) days for the following:

- an appliance, or modification of an appliance when the impression was taken prior to the date of termination;
- a crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;
- root canal therapy when the pulp chamber was opened prior to the date of termination.

- (See also **General Exclusions** section) –

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

Criminal Activities - Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

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

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies - Any services, care or supplies not specifically listed as Eligible Expenses.

Outside United States or Mexico - Charges incurred outside of the United States or Mexico if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

COORDINATION OF BENEFITS (COB)

Benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides benefits or services for health care services:

group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan; or

governmental benefits, as permitted by law.

An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for nonmedical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The coverages of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Claim Determination Period - A period which commences each July 1 and ends at 12 o'clock midnight on the next succeeding June 30, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Plan Year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. The first of the following rules that describes which pays its benefits first is the rule that will be used.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary.

Non-Dependent vs. Dependent - The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated (whether or not they have ever been married), or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

COORDINATION OF BENEFITS, *continued*

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they even have been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. 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 is ignored.

Longer vs. Shorter Length of Coverage - The benefits of the plan which has covered the Claimant for the longer period of time are determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

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

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees

To participate in the coverages of the Plan, an Employee must be in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work at least 21 hours per week.

An Employee will be deemed in "active employment" 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.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

NOTE: Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees

An Employee's coverage is effective, subject to timely enrollment, on the first day of the month following completion of sixty (60) consecutive days of active employment in an eligible status.

If Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage will become effective only in accordance with the "Late Enrollment/Re-Enrollment" provision below.

Eligibility Requirements - Dependents

An eligible Dependent of an Employee is:

a legally married spouse;

a registered domestic partner;

a child under age 26 without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. For these purposes a "child" will include:

- a natural child;
- a stepchild who resides with the Employee;
- a child placed under the legal guardianship of the Employee;
- a foster child who is living in a regular parent-child relationship with the Employee and with the expectation that the Employee will continue to rear the child into adulthood. To establish the child's eligibility, the Employee must submit evidence of a bonafide foster child relationship, identifying the foster child by name and setting forth all the relevant aspects of the relationship. A child placed in a home by a welfare agency which obtains control of and provides for maintenance of the child is not an eligible dependent;
- a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun;
- notwithstanding any main support and care requirements, a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a));

NOTE: An eligible Dependent does not include:

- a spouse or domestic partner following legal separation or a final decree of dissolution or divorce;
- any person who is on active duty in a military service;
- any person who is eligible and has enrolled as an Employee under the Plan;
- any person who is covered as a Dependent of another Employee under the Plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Effective Date - Dependents

Subject to the Effective Date Provision and timely enrollment, Dependents who are eligible and enrolled concurrently with the Employee will have coverage effective on the Employee's coverage effective date. A Dependent acquired later may become covered only if the Employee makes written application for coverage for the Dependent. If application is made:

- on or before the date the Dependent meets the eligibility requirements, the Dependent's coverage will be effective on the date of eligibility; or
- after the date of eligibility but within thirty-one (31) days of that date, the Dependent will become covered on the date application is made; or
- after thirty-one (31) days beyond the date of eligibility, the Dependent's coverage will be effective only in accordance with the "Late Enrollment/Re-Enrollment" provision.

NOTE: A Dependent's coverage will never be effective prior to the Employee's effective date.

Late Enrollment / Re-Enrollment

If application is made more than thirty-one (31) days after an individual's eligibility date or completion of the Plan's waiting period requirement, coverage will not be effective until proof of good dental health is submitted and approved. An effective date will be assigned upon approval.

Proof of good dental health will also be required if an individual applies to re-enroll in the Plan after coverage has terminated due to Employee's failure to make the required contribution for such coverage.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual, who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage under the Plan at a later date if:

he was covered under another group health plan or other health insurance coverage at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);

ELIGIBILITY AND EFFECTIVE DATES, *continued*

- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer; and
- the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTE: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application;

where birth, adoption or placement for adoption is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). "Placement for adoption" means the assumption and retention by the Employee of the legal obligation for the total or partial support of a child to be adopted. Placement ends whenever the legal support obligation ends. The "triggering event" date for a newborn adoptive child is the date of birth if the child is placed with the Employee within thirty-one (31) days of birth and is enrolled within that 31-day period.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

Court or Agency Ordered Coverage – In accordance with state and federal law, if the Plan receives a Medical Child Support Order (MCSO) from a state court or agency and such order is determined by the Plan to be a qualified order (QMCSO), the child shall be enrolled as of the earliest possible date following such determination.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

If a court has ordered that coverage be provided for a covered Employee's spouse or minor child, Employee may enroll such Dependent under the Plan. Application, however, must be made within thirty-one (31) days of the issuance of the court order and coverage will be effective on the date specified in the court order.

Reinstatement / Rehire

If an Employee is rehired or returns to an eligible status within 12 weeks after termination of Plan coverage and completes the necessary enrollment form, such Employee (and any of his Dependents who were covered at point of termination) will have coverage become effective the day of Employee's return to active and eligible status. A new waiting period requirement will not be applied.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). The Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with Federal law, certain Employees who return to employment following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan (for themselves and any Dependents who were covered prior to the military assignment). Neither the waiting period requirement nor any Plan limitations with reference to pre-existing conditions will apply. However, this provision is intended to comply with the minimum requirements of the Veteran's Re-employment Rights Law and, if it is in conflict or incomplete in any way, such law will prevail.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Effective Date Provision

If an Employee is not in active employment due to injury or illness on the date coverage would otherwise become effective, the coverage will not become effective until the date that he/she returns to active employment. If an Employee is not in active employment on the date he/she would otherwise be subject to any change in coverage or benefits as the result of an amendment to the Plan or a change in the person's classification, the change in coverage or benefits will not become effective until he/she returns to active employment.

In order for coverage to become effective on the date it is scheduled, a Dependent must be able to actively perform the normal, regular and customary duties of a person in good health and of like age and sex. If there is any reason, including confinement at home, in a Hospital or other facility, that a Dependent is not normally active, then the Dependent's coverage will not go into effect. In such case, the coverage will not be effective until the date that the Dependent can actively perform his/her normal duties. The same limitations also apply to any scheduled change in coverage or benefits. Further, a Dependent's coverage or change in coverage will not become effective until the Employee's coverage or change in coverage has also become effective.

NOTE: This Effective Date Provision will NOT apply to: (1) a Dependent child born while the Employee is covered under the Plan and who would otherwise have coverage effective on the date of birth, (2) an adopted child of the Employee as defined by law, whether or not the adoption has become final, or (3) during an FMLA leave.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage without having to provide evidence of good dental health. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan;

termination of Employee's eligibility or termination of participation in the Plan by the Employee;

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

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

Dependent Coverage Termination

A Dependent's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or discontinuance of Dependent coverage under the Plan;

termination of the coverage of the Employee;

at midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped Dependent Children

If an already covered Dependent child attains the age which would otherwise terminate his status as a "Dependent," and:

if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan; and

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and

such child is primarily dependent upon the Employee for support and maintenance;

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

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

Extension of Coverage During Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for a person entering military service. This includes the right to extend Plan coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

SUBMITTING A CLAIM

Procedures for Submitting a Claim

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be submitted to the claims office within the filing time limits:

- Dental work incurred between January 1 through June 30 must be submitted by September 30
- Dental work incurred between July 1 through December 31 must be submitted by March 31

A claim must name the Plan, a specific Claimant, a specific dental condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with the following office to handle claims communications and benefit determinations for the Plan. All claims should be directed to:

EBA&M - Employee Benefits Administration & Management Corporation
18002 Cowan
Irvine, CA 92614

Assignments to Providers

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing a claim, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.).

Important: These claims procedures address the periods within which benefit determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval, as governed by ERISA.

CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of material needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant – see definition of “full notice” below.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of “full notice” below.
Claimant Makes Initial <u>Complete</u> Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of “full notice” below.
Claimant Appeals	See “Appeals Procedures” subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).
“Full notice” means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.	

Authorized Representative May Act for Claimant

Any of the above actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial.

CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial within the time frames required by law (see **Claims Time Limits and Allowances**). The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits;

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (comments, documents, records, etc.) in support of his appeal.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits. The Plan will also disclose the names of any health professionals consulted as part of the claim process.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame (see **Claims Time Limits and Allowances**).

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the decision;

- reference to the pertinent Plan provisions on which the decision is based;

- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. The Plan will also disclose any documents that were created or received by the Plan during the appeal process;

- identification of any experts whose advice was obtained in connection with the initial claim denial;

- a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

DEFINITIONS

When capitalized within, the following items will have the meanings shown below.

Benefit Document – A document that describes one (1) or more benefits of the Plan.

Claimant - Any Covered Person for whom a claim is submitted for benefits under the Plan.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Covered Person - A covered Employee and a covered Dependent). See **Eligibility and Effective Dates** section for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Dentist - An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. A physician (M.D.) will be considered to be a Dentist when he performs any dental services within the operating scope of his license.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense which is (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Benefit Document.

Employee - see **Eligibility and Effective Dates** section

Employer - An Employer participating in the Plan.

Fiduciary – An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Plan Year - The period of time commencing at 12:01 A.M. on July 1 of each year and ending at 12:01 A.M. on the next succeeding July 1.

GENERAL PLAN INFORMATION

FUNDING – SOURCES AND USES

Employee & Employer Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a Section 125 pre-tax premium plan.

Taxes

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

ADMINISTRATIVE PROVISIONS

Administration

Certain benefits of the Plan are administered by Contract Administrator(s) under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s).

Amendment or Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right:

- to determine eligibility for benefits or to construe the terms of the Plan;
- to alter or postpone the method of payment of any benefit; and
- to amend any provision of these administrative provisions; and
- to make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Facility of Payment

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

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

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Benefit Document and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

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

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions, but the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan documents. No action may be brought for benefits provided by the Plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one year after the date of such decision.

Loss of Benefits

The following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification

In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Purpose of the Plan

The purpose of the Plan is to provide certain dental benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The Plan is not a plan of insurance.

Reimbursements

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

Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Benefit Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee or Dependent will make a good faith attempt to assist the Contract Administrator in such recovery.

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

Rights Against the Plan Sponsor or Employer

Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Type of Plan

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s) and their eligible Dependents.

This is a limited scope dental plan and is excepted from the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as that act applies to health status discrimination in eligibility.

Workers' Compensation

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

STATEMENT OF RIGHTS

Plan participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Plan participant shall be entitled to:

Receive Information About His/Her Plan and Benefits. This includes the right to:

examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, 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 a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage. This includes:

the right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage; and

reduction or elimination of exclusionary periods of coverage for preexisting conditions under a Plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after his/her enrollment date in the Plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Enforce His/Her Rights

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to \$110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

NOTE: a Domestic Partner and his/her/children are not Qualified Beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if an Employee who is a Qualified Beneficiary elects COBRA continuation coverage for himself/herself, he/she may also elect to continue coverage for his/her/ Domestic Partner and Children or Qualified Dependents if they are covered under the Plan on the day before the Qualifying Event.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his/her portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his/her or her Medicare coverage is in effect and has terminated his/her coverage hereunder;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notice Responsibilities - If the Qualifying Event is Employee's termination, reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within forty-four (44) days of the event. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

In the following instances, the Employee or Qualified Beneficiary is required to provide notice to the Plan: (1) when the Qualifying Event is divorce or separation or a child losing Dependent status, (2) when a second Qualifying Event occurs after a Qualified Beneficiary has become entitled to COBRA with a maximum duration of 18 or 29 months, or (3) when a Qualified Beneficiary entitled to COBRA for a maximum of 18 months has been determined by the Social Security Administration to be disabled during the first 60 days of COBRA coverage or when any such individual has been determined by the Social Security Administration to no longer be disabled. Notice to the Plan must be made in accordance with the requirements as included in the Plan Sponsor's COBRA General or Initial Notice. Notice must include documentation that a Qualifying Event or other event allowing extended coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter). Notice must be mailed to the address shown on the form.

In the case of a divorce, legal separation or a child losing Dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the Qualifying Event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice (a copy of which is included in this SPD). If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice (a copy of which is included in this SPD). Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

It is important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become Qualified Beneficiaries.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

COBRA CONTINUATION COVERAGE, *continued*

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his/her waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his/her deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

- the cost previously charged was less than the maximum permitted by law;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

- the Qualified Beneficiary changes his/her coverage option(s) which results in a different coverage cost.

COBRA CONTINUATION COVERAGE, *continued*

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare; or

for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable period. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his/her or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled. (See also, "Notice Responsibilities".)

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan;

COBRA CONTINUATION COVERAGE, *continued*

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his/her or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

AMENDMENT #1
TO THE 2022 BENEFIT DOCUMENT OF
LEGAL AID SOCIETY OF SAN DIEGO, INC.
DENTAL BENEFITS PLAN

Effective **December 1, 2022**, the above-referenced Benefit Document of "Legal Aid Society of San Diego, Inc." is amended as follows:

1. The *Effective Date – Employees* entry in the **Eligibility and Effective Dates** section is amended as follows:

Effective Date - Employees

- An Employee's coverage is effective, subject to timely enrollment, on the first day of the month following completion of thirty (30) consecutive days of active employment in an eligible status. If the 30th day falls on the 1st of the month, coverage is effective the following month. For example, if an employee was hired on February 1st and the 30th day was March 1st, coverage would be effective April 1st.

If Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage will become effective only in accordance with the "Late Enrollment/Re-Enrollment" provision below.

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This amendment is accepted by:

Signature of Authorized Representative

Date

NOTICE TO PLAN PARTICIPANT: INSERT THIS AMENDMENT INTO YOUR BENEFIT BOOKLET. IT IS AN AMENDMENT TO YOUR SUMMARY PLAN DESCRIPTION.

AMENDMENT #2
TO THE 2021 BENEFIT DOCUMENT OF
LEGAL AID SOCIETY OF SAN DIEGO, INC.
DENTAL BENEFITS PLAN

Effective **December 1, 2024**, the above-referenced Benefit Document of the "Legal Aid Society of San Diego, Inc. Dental Benefits Plan" is amended as follows:

1. The *Effective Date – Employees* entry in the **Eligibility and Effective Dates** section is amended as follows:

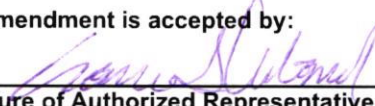
Effective Date - Employees

An Employee's coverage is effective, subject to timely enrollment, on the first day of the month following date of hire.

If Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage will become effective only in accordance with the "Late Enrollment/Re-Enrollment" provision below.

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This amendment is accepted by:



Signature of Authorized Representative

12/05/24

Date

NOTICE TO PLAN PARTICIPANT: REVIEW THIS AMENDMENT CAREFULLY AND THEN INSERT IT INTO YOUR BENEFIT BOOKLET. THIS AMENDMENT REFLECTS CHANGE(S) TO YOUR SUMMARY PLAN DESCRIPTION AND MAY INCLUDE MATERIAL MODIFICATIONS (REDUCTIONS) IN PLAN BENEFITS.