

***Dental Plan Document
for Hunt & Sons, Inc.***



Effective: January 01, 2022

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

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by Hunt & Sons, Inc. (the "Company" or the "Plan Sponsor") as of January 1, 2022, hereby sets forth the provisions of the Hunt & Sons, Inc. Employee Benefit Plan (the "Plan"). Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

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. 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.

Hunt & Sons, Inc.

By: Joshua M. Hunt

Name: Joshua M. Hunt

Title: CEO

Date: 4/26/23

ELIGIBILITY

Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month following completion of a Service Waiting Period of 30 days. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Reinstatement of Coverage

An Employee who is terminated and rehired will be treated as a New Employee upon rehire only if the Employee was not credited with an Hour of Service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding period of employment.

Upon return, coverage will be effective immediately following rehire, so long as all other eligibility criteria are satisfied.

Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.
4. If applicable, for a Dependent Child, the date the Dependent Child becomes eligible due to a qualifying status change event, as outlined in the Section 125 plan.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan.

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence.
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must meet all of the following requirements:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury.
2. Be Medically Necessary.
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she meets all of the following requirements:

1. Is a Dependent Child of a Participant under the terms of the Plan or coverage.

2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious illness or injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Application (paper or electronic as applicable). Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.
2. Birth of Dependent Child. A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth **if written application to add the Child is received by the Plan Administrator within 31 days following the Child's date of birth**. The application must also be accompanied by any required contribution, ongoing, as the case may be. If written application to add a newborn Child is received by the Plan Administrator AFTER the 31-day period immediately following the Child's date of birth, the Child is considered a late enrollee and not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.
3. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 31 days of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.
4. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.
5. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
6. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
7. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: *It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.*

Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
 - a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
 - b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
 - c. The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
 - d. The Plan is no longer offering benefits to a class of similarly situated individuals.
 - e. The benefit package option is no longer being offered and no substitute is available.
 - f. The employer contributions under the other coverage were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements are met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the first day of the first calendar month following enrollment.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become **effective on January 1st**, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the time frame specified by the Plan Administrator.

Relation to Section 125 Cafeteria Plan

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions, and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan.

- b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
 - a. Be in writing.
 - b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
 - c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines). **NOTE:** *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.*
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The last day of the month in which the Employee is no longer eligible for such coverage under the Plan.
5. The last day of the month in which the termination of employment occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such disability or inability.
 - b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
 - c. Upon the Child's no longer being dependent on the Employee for his or her support.
6. The day immediately preceding the date such person is no longer a Dependent, as defined herein, except as may be provided for in other areas of this section.
7. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
8. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

NOTE: *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plans.*

HUNT & SONS, INC. #11005
DENTAL SUMMARY OF BENEFITS

Member & Provider Services: 1-844-814-3437

Provider Directory: UniCare.com

Calendar Year Maximum Benefits for: Dental			
	In-Network Anthem DNAS	Out-of- Network	
Annual Deductible			
Individual	\$0.00	\$50.00	
Family Unit	\$0.00	\$150.00	
Annual Maximum Benefit (Calendar Year)	\$2,000	\$1,500	
Orthodontia Lifetime Maximum Benefit	\$2,000	\$2,000	
Class I: Preventive Dental Services <i>Deductible waived</i>			
Preventive Dental Services	In-Network Plan Pays	Out-of-Network Plan Pays	Limitations
Comprehensive/Periodic Exams	100%	100%	Limited to 1 per six-month period
Evaluations/Re-Evaluations of Periodontal Evaluations			
Prophylaxis (cleaning and scaling) for adults and dependent children	100%	100%	Limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per six-month period (during the six-month period, benefits under either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both)
Topical fluoride treatment for Dependent children under age 14	100%	100%	Limited to 1 per six-month period; Topical fluoride varnish is not covered

X-Rays:			
Intraoral complete series x-rays, including bitewings and 10 to 14 periapical x-rays, or panoramic film	100%	100%	Limited to 1 per 60-month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year
Bitewing x-rays (two or four films)	100%	100%	Limited to 1 per 12-month period. Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year
Other X-Rays:			
Intraoral periapical x-rays	100%	100%	Payable amount for the total of bitewing and intraoral periapical x-rays is limited to the maximum allowance for an intraoral complete series x-rays in a calendar year
Intraoral occlusal x-rays	100%	100%	Limited to 1 film per arch, per six-month period
Extraoral x-rays	100%	100%	Limited to 1 film per six-month period
Other x-rays (except film related to orthodontic procedures or temporomandibular joint dysfunction)	100%	100%	None
Sealants	100%	100%	Limited to 1 application to an unrestored occlusal surface of a permanent molar tooth per 36-month period, for dependent children under age 14
Limited oral exams (emergency oral exams)	100%	100%	Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit
Space maintainers, including all adjustments made within months of installation	100%	100%	Limited to dependent children under age 14
Palliative (emergency) treatment of dental pain	100%	100%	Considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit
Basic Dental Services (Class II)			

<i>Deductible applies</i>			
Basic Dental Services	In-Network Plan Pays	Out-of-Network Plan Pays	Limitations
Stainless steel crowns	90%	80%	Limited to 1 per 36-month period for teeth not restorable by an amalgam or composite filling for dependent children to age 19
Pulpotomy (primary teeth only)	90%	80%	None
Root canal therapy (including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care)	90%	80%	Limited to 1 time on the same tooth per 24-month period; Limited to permanent teeth only
Apicoectomy/periradicular surgery (anterior, bicuspid, molar, each additional root), including all pre-operative, operative and post-operative x-rays, bacteriologic cultures, diagnostic tests, local anesthesia, and routine follow-up care	90%	80%	None
Retrograde filling - per root	90%	80%	None
Root amputation - per root	90%	80%	None
Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy.	90%	80%	None
Periodontal scaling and root planing	90%	80%	Limited to four teeth or more per quadrant, limited to a minimum of 5mm

			pockets on at least four teeth per quadrant, 1 time per quadrant per 24-month period; Limited to one to three teeth per quadrant, limited to minimum of 5mm pockets on one to three teeth, limited to 1 treatment per quadrant per 24-month period. Root planning is generally not a benefit in the same quadrant for at least a 24-month period following the completion of active therapy. Under unusual circumstances, additional documentation can be submitted to us for review. Root planing is not a benefit until 36-months after surgery in the same area
Periodontal maintenance procedure (following active treatment)	90%	80%	Limited to 1 dental prophylaxis or 1 periodontal maintenance procedure per 6-month period (during the 6-month period, benefits include either 1 dental prophylaxis or 1 periodontal maintenance procedure, but not both)
Periodontal maintenance procedures (periodontal prophylaxis) may be used in those cases in which a patient has completed active periodontal therapy, and commencing no sooner than three-months thereafter.	90%	80%	The procedure includes any examination for evaluation, curettage, root planing and/or polishing as may be necessary.
Periodontal related services as follows: gingival flap procedures; gingivectomy procedures; osseous surgery; pedicle tissue grafts; soft tissue grafts; subepithelial tissue grafts; bone replacement grafts; guided tissue regeneration; crown lengthening procedures - hard tissue	90%	80%	Limited to 1 time per quadrant of the mouth in any 36-month period with changes combined for gingivectomy, gingival flap procedure, pedicle grafts, soft tissue grafts, subepithelial tissue grafts, or osseous surgery performed in the same quadrant within the same 36-month period.

Oral surgery services as follows: simple extraction; surgical extractions, including extraction of symptomatic third molars (wisdom teeth); alveoloplasty; vestibuloplasty; removal of exostosis (maxilla or mandible); frenulectomy (frenectomy or frenotomy); excision of hyperplastic tissue (per arch)	90%	80%	Includes an allowance for local anesthesia and routine post-operative care.
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	90%	80%	Limited to permanent teeth only.
Root removal - exposed roots	90%	80%	None
Biopsy	90%	80%	None
Incision and drainage	90%	80%	None
General anesthesia and intravenous sedation	90%	80%	Limited as follows: considered for payment as a separate benefit only when medically necessary (as determined by us) and when administered in the Dentist's office or outpatient surgical center in conjunction with complex oral surgical services, which are covered under the policy. Oral sedation is not a covered benefit
Nitrous oxide limited to dependent children through age 6	90%	80%	None
Consultation, including specialist consultation	90%	80%	Limited as follows: considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered on the same date; benefits will not be considered for payment if the purpose of the consultation is to describe the Dental Treatment Plan.
Amalgam and composite restorations	90%	80%	Limited as follows: multiple restorations on one surface will be considered a single filling; multiple restorations on different surfaces of the same tooth will be considered connected; benefits for replacement of an existing restoration will only be considered for payment if at least 12-months have passed since the existing restoration was placed if the covered

			person is under age 19, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; or 36-months have passed since the existing restoration was placed if the covered person is age 19 or older, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; additional fillings on the same surface of a tooth in less than 12-months for patients up to age 19 or in less than 36-months for patients age 19 or over, by the same office or same Dentist are not a benefit, except in extraordinary circumstances involving external, violent and accidental means or due to radiation therapy; sedative bases and copalite are considered part of the restorative service and are not paid as separate procedures; composite restorations are also limited as follows: mesial-lingual, distal-lingual, mesial-facial and, distal-facial restorations on anterior teeth will be considered single surface restorations; acid etch is not covered as a separate procedure; benefits limited to anterior teeth only; based on network type, benefits for composite resin restorations on posterior teeth may be limited to the benefits for the corresponding amalgam restoration; pins, in conjunction with a final amalgam restoration.
Major Dental Services (Class III)			

<i>Deductible applies</i>			
Major Dental Services	In-Network Plan Pays	Out-of-Network Plan Pays	Limitations
Inlays and onlays (metallic)	60%	50%	Limited as follows: covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to persons age 16 and above; inlays and onlays on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation
Porcelain restorations on anterior teeth	60%	50%	Limited as follows: covered only when the tooth cannot be restored by an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to persons age 16 and above; porcelain restorations on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation
Cast crowns	60%	50%	Limited as follows: covered only when the tooth cannot be restored by

			an amalgam or composite filling; covered only if more than 5 years have elapsed since last placement; limited to permanent teeth (cast crowns on over-retained primary teeth are not covered); limited to persons age 16 and above; crowns on third molars where adjacent first and second molars are present or where there is no occlusion with opposing are not covered; crowns on teeth which may be restored with an amalgam or composite resin filling are not covered; build-up procedure is not covered as a separate service; benefits based on the date of cementation
Crown lengthening	60%	50%	Limited to single site when contiguous teeth are involved.
Recementing inlays, crowns and bridges	60%	50%	Limited to three per tooth.
Post and core	60%	50%	Covered only for endodontically treated teeth requiring crowns; one post and core is covered per tooth
Full dentures	60%	50%	Limited as follows: limited to 1 full denture per arch; replacement covered only if five years have elapsed since replacement AND the full denture cannot be made serviceable; service includes any adjustment or reline performed within 12-months of initial insertion; we will not pay additional benefits for personalized dentures or overdentures or associated treatment; benefits for dentures are based on the date of delivery.

Partial dentures, including any clasps and rests and all teeth	60%	50%	Limited as follows: limited to 1 partial denture per arch; replacement covered only if five years have elapsed since replacement AND the partial denture cannot be made serviceable; service includes any adjustment or reline performed within 12-months of initial insertion; there are no benefits for precision or semi-precision attachments; benefits for partial dentures are based on the date of delivery.
Denture adjustment	60%	50%	Limited to 1 time per 12-month period, and adjustments made more than 12-months after the insertion of the denture.
Repairs to full or partial dentures, bridges and, crowns	60%	50%	Limited to repairs and adjustments performed 3 in a lifetime after the initial insertion.
Rebasing dentures	60%	50%	Limited to 1 time per 12-month period.
Relining dentures	60%	50%	Limited to 1 time per 12-month period; and relines performed more than 12-months after initial insertion of the denture.
Tissue conditioning	60%	50%	Limited to repairs and adjustment performed once per 12-month period.
Fixed bridges (including Maryland bridges)	60%	50%	Limited as follows: limited to persons age 16 and above; benefits for the replacement of an existing fixed bridges are payable only if the existing bridge is more than five years old and cannot be made serviceable; a fixed bridge replacing the extracted portion of a hemisected tooth is not covered; placement and replacement of cantilever bridges on posterior teeth will not be covered; benefits for bridges are based on the date of cementation.

Recementing bridges	60%	50%	Limited to repairs or adjustment performed more than 12-months after the initial insertion.
Endodontic endosseous implant and endosseous implant	60%	50%	Limited as follows: benefits for the replacement of an existing implant are payable only if the existing implant is more than 60-months old and cannot be made serviceable.
Implant supported prosthetics	60%	50%	Allowance includes the treatment plan and local anesthetic: abutment supported crown; implant supported crown; abutment supported retainer for fixed partial denture; implant supported retainer for fixed partial denture; implant/abutment supported fixed denture for completely edentulous arch; implant/abutment supported fixed denture for partially edentulous arch.
Class IV: Orthodontia			
Ortho Coverage	In-Network Plan Pays	Out-of-Network Plan Pays	Limitations
Orthodontia Services	50%	50%	Orthodontia Lifetime Family Maximum: \$2,000

DENTAL EXPENSES NOT COVERED

The following list includes some common dental charges which are not covered under the Plan:

- Charges for dental care that is not medically necessary as prescribed by a physician or dentist;
- Charges for any services not shown in the Summary of Dental Benefits above;
- Charges incurred for completing claim forms or for providing reports;
- Charges for broken or missed appointments;
- Charges in excess of the maximum amount payable under the Plan (see "Maximum Allowed Amount");
- Charges you are not legally obligated to pay;
- Charges for benefits payable under any other coverage of this Plan;
- Charges for services and supplies furnished in a U.S. Government hospital;
- Charges for services provided by a person who normally lives with the Plan participant, you or your spouse, or you or your spouse's parent, child, brother, or sister;
- Services or supplies which are covered by any employer's liability laws;
- Services or supplies which are covered by any workers' compensation or occupational disease laws;
- Services that do not meet the standards of dental practices, accepted by the American Dental Association;
- Treatment which is considered to be experimental by the dental profession;
- Treatment received because of injury, disease, or dental defect resulting from declared or undeclared war or act of war;
- Treatment received before becoming covered under the Plan or after coverage terminates.
- Implants (surgical placement or removal)
- T.M.J. related services
- Bone Grafting
- Tissue Grafting (if related to dental implants)
- Crown lengthening
- Discoloration treatment (whitening/bleaching)
- Lost or Stolen Prosthetics or Appliances
- Oral hygiene Supplies
- Splinting teeth
- Missed appointments or insurance forms
- Occlusal guard and splints. Night Guards

DENTAL EXPENSE BENEFIT

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses incurred by a covered person. The dental benefit is a percentage of the customary and reasonable amount for incurred covered dental expenses, as shown on the Schedule of Benefits.

PREDETERMINATION OF BENEFITS

"Predetermination of benefits" means that the dentist submits a dental treatment plan to the claims processor before treatment starts for:

1. Any basic or major treatment expected to result in charges for covered dental expenses of five hundred dollars (\$500) or more; and
2. For all orthodontic treatment

The claims processor will inform the covered person the level of benefits from the Plan for the covered dental services, supplies and treatments recommended. This pre-estimate is not an agreement for payment of the dental expenses.

Pre-Treatment Estimate of Dental Expenses: BRMS believes a patient has a right to know the amount of benefits payable under the Dental Plan for a course of dental treatment before it begins. If a patient expects charges for services and supplies to exceed \$500, he or she may first have the dentist submit to Anthem Blue Cross of California a Pre-Treatment Plan Form which lists the charges for the course of treatment. The Claims Administrator, in turn, will set out on the form the amount of benefits payable under the Plan and return it to the dentist.

DEDUCTIBLE **INDIVIDUAL DEDUCTIBLE**

The individual deductible is the dollar amount of covered expense which each covered person must incur during each plan year before the Plan pays applicable benefits. The individual deductible amount is shown on the Schedule of Benefits.

FAMILY DEDUCTIBLE

If, in any plan year, covered members of a family incur covered expenses that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, the family deductible will be considered satisfied for all family members for that plan year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The Plan pays a specified percentage of the customary and reasonable amount for covered expenses. That percentage is listed on the Schedule of Benefits. The covered person is responsible for the difference.

MAXIMUM BENEFIT

The maximum plan year benefit payable on behalf of a covered person for covered dental expense is stated on the Schedule of Benefits. If the covered person's coverage under the Plan terminates and he subsequently returns to coverage under the Plan during the plan year, the maximum benefit will be calculated on the sum of benefits paid by the Plan.

ALTERNATIVE TREATMENT

In the event the dentist recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining as a result of

the covered person's choice to obtain the higher-cost treatment will be the covered person's responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is incurred, except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the claims processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

DENTAL SERVICES – RESULT OF AN INJURY

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an injury. Treatment must be rendered within six (6) months of the date of such injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

DENTAL PROVIDER DEFINITIONS

Certain words and terms used herein shall be defined as follows:

Dentist- A licensed Doctor of Dental Medicine (D.M.D) or a licensed Doctor of Dental Surgery (D.D.S.), other than a close relative of the covered person

Professional Provider- A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers include, but are not limited to:

- Dental Hygienist
- Dentist

COORDINATION OF BENEFITS (COB)

All dental 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:

group, blanket or franchise insurance coverage;

coverage under a labor-management trustee plan;

any union welfare plan;

any employer organization plan or employee benefit organization plan;

coverage under any law (including any federal or state or other governmental plan or law);

coverage under any plan solely or largely tax-supported or otherwise provided for, by or through action of any government.

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 non-medical components of group long-term care policies, (5) Medicare supplement policies, or (6) Medicaid.

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 that is covered by 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.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be its normal liability minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using

The "Order of Benefit Determination below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay its normal liability minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made on a claim-by-claim basis. No savings or credit reserves will be recognized.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits. That is, a person eligible for Medicare Part A and Part B is deemed to be covered under Medicare Part A and Part B.

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.

The plan that covers the Claimant as an active employee or a dependent of an active employee is primary over a plan providing coverage under a right of continuation pursuant to federal or state law (e.g. COBRA). 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.

Non-Dependent vs. Dependent - The benefits of a plan that 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 that 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 or are not separated (whether or not they have ever been married), or (2) 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.

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 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 ever 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.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that 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 Claims 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 as allowed under the Health Insurance Portability and Accountability Act (HIPAA). Any person claiming benefits under This Plan will furnish to the Claims 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 Claims 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.

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extensions of Coverage During Absence From Work

If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any.

- the date the person becomes covered under any other group plan for benefits of a type similar to those provided by this Plan;

- the end of the month for which the last contribution was paid, if such contribution is required;

- the date of termination of this Plan.

NOTE: To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Plan Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Continued coverage under the FMLA is allowed during up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child;

- the placement of a child with the Employee for adoption or foster care;

- to care for a spouse, child or parent of the Employee where such relative has a serious health condition;
or

- Employee's own serious health condition that makes him unable to perform the functions of his or her job.

In accordance with the National Defense Authorization Act for Fiscal Year 2008 and 29 CFR § 825.127, FMLA provides up to 26 weeks of unpaid leave to a qualified employee to care for a family member who is an Armed Forces servicemember recovering from a serious illness or injury incurred in the line of duty. An employees may take caregiver leave only to care for a servicemember who is the employee's spouse, son,

daughter, parent or next of kin (defined as the employee's nearest blood relative). For purposes of this section, a serious illness or injury is defined as a condition incurred while on active duty that may render the servicemember medically unfit to perform the duties of his office, grade, rank or rating. A covered servicemember is a person who is a member of the armed forces, National Guard or Reserves. Former members of the armed forces, National Guard or Reserves do not fall within the definition of covered servicemembers.

The above military extension will apply also to qualifying exigencies as defined in 29 CFR § 825.126.

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During U.S. 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 an Employee entering military service.

USERRA provides for the continuation of health benefits for Employees who are on military leave. If an Employee was covered under the Plan immediately prior to being ordered to active military duty, coverage may continue for up to 18 months (or up to 24 months for elections made on or after December 10, 2004), or the duration of active military service, whichever is shorter. The Employee may be required to pay the cost of coverage. The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost if the military leave is less than 31 days.

Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

on the first full business day following completion of military service for military leave of 30 days or less; or

within 14 days of completion of military service for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

The Employee who is ordered to active military service (and that Employee's eligible Dependent(s)) are considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Coverage provided under USERRA will run concurrently with any right to continue coverage under COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the above stipulations.

For more information about rights under USERRA and military leaves, a VETS directory and additional information is available at www.dol.gov/vets.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific treatment or service or procedure/revenue code 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.

A "claim" does not include a request for a pre-treatment estimate for proposed services or supplies or an estimate of an employee's share of claims costs.

The Plan Sponsor handles all claims communications, claims processing, and initial benefit determinations for the Plan. Contact information for claims is provided below. The Plan Sponsor is responsible for making final benefit determinations for the Plan.

A Post-Service Claim is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within twelve (12) months after the date services are rendered.

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

HOW TO FILE A CLAIM

BRMS will accept the "Universal Claim Form" used by most dentists. Please ensure that the claim form includes your name, social security number and group number. Completed claim form(s), need to be mailed directly to:

Attn: Claims Department
Benefit & Risk Management Services, Inc (BRMS)
P.O. Box 2140
Folsom, CA. 95763

If you have any questions on a claim, please feel free to call BRMS at:

1-844-814-3437

Monday through Friday 7:00 a.m. to 6:00 p.m. (PST)

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other 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 proof of loss, 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.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

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 that 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.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial <u>Incomplete</u> Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. The Claimant has 48 hours from receipt of notification of incomplete information to provide requested information.
Plan Receives <u>Completing</u> Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial <u>Complete</u> Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.
An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.	
Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, considering the urgency of the medical situation.	

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Concurrent Care Claim - defined below Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.

A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Non-Urgent Claim Claimant Makes Initial <u>Incomplete</u> Claim Request Plan Receives <u>Completing</u> Information Claimant Makes Initial <u>Complete</u> Claim Request Claimant Appeals Plan Responds to Appeal	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification. Plan responds with written or electronic benefit determination within 15 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. Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below. Must be filed within 180 days of notice of denial. See "Appeal Procedures" subsection. Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).
"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 15-day period.	
"POST-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Claimant Makes Initial <u>Incomplete</u> Claim Request Plan Receives <u>Completing</u> Information Claimant Makes Initial <u>Complete</u> Claim Request Claimant Appeals Plan Responds to Appeal	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request. 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. 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. Must be filed within 180 days of notice of denial. See "Appeals Procedures" subsection. 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 that 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. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

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 that 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;

if the denial is based on necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

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

NOTE: A “claim” does not include a request for a pre-treatment estimate for proposed services or supplies or an estimate of an Employee's share of claims costs.

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. Appeals should be filed with the Claim Administrator. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

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.

NOTE: 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.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame.

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;

if the denial is based on necessity or experimental treatment, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

GENERAL PLAN INFORMATION

Name of Plan:	Benefit Plan	Hunt & Sons, Inc. Employee Dental
Plan Sponsor:	Benefit Plan	Hunt & Sons, Inc. Employee Dental
Address:		5750 S. Watt Avenue Sacramento, CA 95829
Business Phone Number:		(916) 383-4868
Participating Employer(s):		Hunt & Sons, Inc.
Plan Sponsor ID Number (EIN):		94-2209320
Plan Year:		January 1 through December 31
Plan Benefits:		Dental
Named Fiduciary:		Hunt & Sons, Inc.
Address:		5750 S. Watt Avenue Sacramento, CA 95829
Agent for Service of Legal Process:		Hunt & Sons, Inc.
Address:		5750 S. Watt Avenue Sacramento, CA 95829
Claims Administrator:	Inc. (BRMS)	Benefit & Risk Management Services,
Mailing Address:		P.O. Box 2140 Folsom, CA 95763
Phone:		(844) 814-3437

FUNDING - SOURCES AND USES

Employee & Employer Obligations

Plan benefits are paid from the general assets of the Plan Sponsor. The Plan Sponsor shall, from time to time, evaluate and possibly adjust the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (Non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be not deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

Self-Funded Benefits

Contributions will be used to provide the non-insured benefits of the Plan.

Administration Expenses

Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Claims Administrator(s) and (2) other reasonable operating expenses of the Plan.

Taxes

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

ADMINISTRATIVE PROVISIONS**Administration (type of)**

Certain benefits of the Plan are administered by a Claims Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Claims Administrator. The Claims Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan

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, without the consent of any participant or beneficiary:

determine eligibility for benefits or to construe the terms of the Plan;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis,

If the Plan is amended or terminated, Covered Persons may not receive benefits as described in this summary. Covered Persons may be entitled to receive different benefits, or benefits under different conditions. However, it is possible for Covered Persons to lose all benefit coverage. This may happen at any time if the employer decides to terminate the Plan or terminate your coverage under the Plan. In no event will Covered Persons be entitled to any vested benefits under the Plan. The provisions of the Plan cannot be modified orally or in any other manner, except by properly adopted amendment.

NOTE: Any amendment or termination of the Plan will not affect payment of a covered expense Covered Persons incur before the amendment or termination.

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. Notwithstanding the foregoing, the Plan will pay benefits in accordance with the terms of a Qualified Medical Child Support Order.

Clerical Error

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

Creditable Coverage Certificates - Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Without evidence of credible coverage, individuals may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) under another employer's group health plan. Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies

In the event that there may be a discrepancy between this Summary Plan Descriptions and the Plan Document, the Plan Document will prevail.

Entire Contract

The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

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

The Plan Sponsor will serve without compensation for such services, but will be entitled to reimbursement of expenses properly and actually incurred in an official capacity. The Plan Sponsor will discharge its 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 Plan Sponsor will administer the Plan and will have the authority to exercise the powers and discretion conferred on it by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan

In carrying out its responsibilities under the Plan, the Plan Sponsor will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, 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 Plan Sponsor 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 its opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Plan Sponsor may delegate to any agent, attorney, accountant or other person or third party selected by it any power or duty vested in, imposed upon, or granted to it by the Plan. However, the Plan Sponsor 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 Plan Sponsor violated its 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 include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the document will not affect the other provisions and the 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, 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 Document.

No legal action may be brought for claims other than breach of fiduciary duty to recover on the Plan: (1) more than three years from the time proof of the claim is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits

To the extent permitted by law, 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 Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

- 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 that 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 take any action it determines appropriate including giving the 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

Physical Examination

The Plan Sponsor at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Sponsor Discretion & Authority

The Plan Sponsor has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Sponsor (or the delegated Claims Administrator acting within the terms of its authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply

The Health Insurance Portability and Accountability Act (HIPAA) requires that health plans protect the confidentiality of Covered Persons' private health information. This protection extends to this Plan.

The Plan and the Plan Sponsor will not use or further disclose protected health information (PHI) except as necessary for treatment, payment health plan operations and Plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan sponsored by the Employer. The Plan is part of an "organized health care arrangement" under which the individual health benefits and the applicable service providers and the applicable insurers may share PHI for treatment, payment and health care operations and may undertake joint activities to manage the organized health care arrangement's operations and improve the quality of health care it provides.

Under HIPAA, Covered Persons have certain rights with respect to their PHI, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. Covered Persons also have the right to file a complaint with the Plan's Complaint Officer or with the Secretary of the U.S. Department of Health and Human Services if they believe their privacy rights under HIPAA have been violated.

The Plan maintains a privacy notice, which provides a complete description of rights under HIPAA's privacy rules. For a copy of the notice, or for questions about the privacy of health information, or to file a complaint under HIPAA, please contact the Plan's Privacy Officer or Complaint Officer, as applicable.

Privacy Officer: Director of Human Resources – 1-844-814-3850

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Qualified Medical Child Support Orders (QMCSO)

In accordance with federal law, the Plan provides medical coverage to certain children (called alternate recipients) if the Plan is directed to do so by a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court, or produced as a result of state-authorized administrative process directing the Plan to include the child in the Employer's coverage. In addition to requiring the Employee to provide coverage for the child, the law authorizes the Employer to make applicable payroll deductions, if any when the Plan Sponsor receives a Medical Child Support Order, it will notify both the Employee and the alternate recipient that the order has been received and what procedures the Plan will use to determine if the order is qualified. Then the Plan Sponsor will decide, on the basis of the Plan's written procedures and within a reasonable time, whether the order is qualified. Both the Employee and the alternate recipient will be notified of the appropriate action taken in accordance with the terms of the QMCSO..

Employees may obtain more information on QMCSO procedures by contacting the Plan Sponsor. A copy of the Plan's procedures is available without charge from the Plan Sponsor.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Claims 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.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - 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. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Claims Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Claims Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer

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 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 document and will not affect the validity, construction or effect of the document provisions.

Termination for Fraud

An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

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.

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:

COBRA Administrator – BRMS P O Box 640, Folsom, CA 95763, 1-916-467-1400.

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 coverage the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that an otherwise eligible 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: COBRA Continuation Coverage rights do not apply to a domestic partner, or to any child of such a partner.

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 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 or her Medicare coverage is in effect;

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).

Non-COBRA 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).

Notification – If the Employer is the Plan Sponsor and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Sponsor must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Sponsor, then the Employer's notification to the Plan Sponsor must occur within 30 days of the Qualifying Event and the Plan Sponsor must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. 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, etc.), the Plan Sponsor 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.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Sponsor must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

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. See NOTE.

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.

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 Sponsor.

Annual enrollment rights that allow Non-COBRA 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.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

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 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 Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. COBRA continuation coverage elections must match coverage that existed immediately prior to the Qualifying Event.

If coverage is modified for similarly situated Non-COBRA 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 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.

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 from the date of the Loss of Coverage. 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 the Employee's entitlement to Medicare before the Employee himself experiences a Qualifying Event that is a termination of employment or reduction in hours, the maximum coverage period for the Dependent is the longer of (1) 36 months from the date the Employee is enrolled in Medicare, or (2) 18 months from the date of the Employee's loss of coverage due to termination of employment or reduction in hours;

for any other Qualifying Event, the maximum coverage period ends 36 months from the date of the loss of coverage due to a 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. Also, this additional period of coverage is available only if the second Qualifying Event would have, but for the original Qualifying Event, resulted in a loss of coverage.

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 have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the COBRA Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, notice must be delivered to the COBRA Administrator within 60 days from the later of: (1) the date of the disability determination, (2) the date of the Qualifying Event, or (3) the date coverage is lost as a result of the Qualifying Event. Also, notice must be provided within the 18-month COBRA coverage period. . The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the COBRA Administrator of the determination. The COBRA Administrator must also be notified within 30 days if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

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 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 that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

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 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 Non-COBRA 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.

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 Non-COBRA 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 Non-COBRA 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 and the Qualified Beneficiary will lose the right to continue coverage under COBRA. 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 COBRA Administrator..

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 coverage option(s) which results in a different coverage cost.

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. Qualified Beneficiaries will be responsible for health care costs.

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.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Sponsor shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Sponsor shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

Non-electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

For More Information

Benefit & Risk Management Services (BRMS) is the COBRA Administrator. Questions regarding the Plan and COBRA continuation coverage can be directed to the COBRA Administrator at: BRMS, P.O. Box 850, Rancho Cordova, CA 95741-0850.

Keep the Plan Informed of Address Changes

In order to protect his family's rights, an Employee should keep his Employer and the COBRA Administrator informed of any changes in his address or the address(s) of his Dependents.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Sponsor be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification - Notification of the Qualifying Event by a covered Employee must be communicated via fax or email by the Plan Sponsor.

Content - Notification must include the name(s), address and phone number of the Qualified Beneficiaries experiencing the Qualifying Event, identify the Plan, the Qualifying Event, and the date of the Qualifying Event.

Time Requirements for Notification - 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 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. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

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. 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.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

HIPAA PRIVACY

HUNT & SONS, INC. EMPLOYEE BENEFIT PLAN

The Plan complies with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of Protected Health Information (herein also "PHI") of Plan participants. PHI is individually identifiable health information that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium.

The plan includes a Benefit Committee that includes the following members:

Chief Executive Officer

Vice President of Sales

Vice President of Finance

Director of Sales and Marketing

Director of Human Resources

Director of Client Administration

Certification - The Plan certifies the following:

- That Protected Health Information (PHI) will be used by and/or disclosed to the Plan Sponsor /Employer consistent with the Privacy Rules. Specifically, the Plan will be permitted or required to disclose PHI to the Plan Sponsor /Employer, without individual authorization(s), for the purpose of Plan administrative functions including:
 - quality assurance and monitoring;
 - claims processing, including the handling of claims appeals;
 - auditing (i.e., to audit payments for claims incurred under the Plan);
 - providing and conducting administrative functions related to payment and healthcare operations for and on behalf of the Plan;
 - requesting proposals for services to be provided to or on behalf of the Plan;
 - investigating fraud or other unlawful acts related to the Plan and committed or reasonably suspected to have been committed by a Plan participant;
- That the Plan is able to disclose PHI to the Plan Sponsor /Employer only on receipt of a certification

by the Plan Sponsor /Employer that the Plan document(s) incorporate(s) the following provisions and that the Plan Sponsor /Employer agrees to:

- not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
 - ensure that any outside parties to whom it provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor /Employer;
 - not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
 - report to the Plan any known inconsistent use or disclosure of the information;
 - make internal practices, books, and records related to PHI available to the Department of Health and Human Services for purposes of determining compliance; and
 - if feasible, return or destroy all PHI that the Employer still maintains in any form and retain no copies of such information.
- That the Plan Sponsor /Employer shall be entitled to receive PHI from:
 - any business associate of the Plan;
 - any person or entity that contracts with any such business associate;
 - any person or entity that contracts with the Plan Sponsor /Employer to provide services to on behalf of the Plan;
 - any health insurer, health insurance issuer or other entity that provides coverage or services to or on behalf of the Plan;
 - any healthcare clearinghouse that provides services or to on behalf of the Plan or with respect to Plan participants;
 - any other person or entity that maintains, or has authority to direct the disclosure of, PHI related to any Plan participant.
 - That Plan participants may: (1) access their PHI, including copying it, (2) amend the information, (3) receive an accounting, on request, of all their PHI disclosures, and (4) follow a specific process to address complaints.
 - That the Plan will ensure availability to the Department of Health and Human Services (HHS) of the Plan's internal practices, books and records on uses and disclosures of Protected Health Information (PHI).

Separation of Plan & Plan Sponsor /Employer - To provide adequate separation ("firewalls") between the Plan and the Plan Sponsor /Employer in order to assure protection of PHI, the Plan is amended to reflect that:

- Only the following employees of the Plan Sponsor /Employer will be given access to PHI received from the Plan:
 - Director of Compensation and Benefits;
 - Benefits Manager;
 - Benefits Analyst.
- Access to and use of PHI by the employees identified above is restricted to Plan administration functions that the Plan Sponsor /Employer performs for the group health plan;
- Any issues of noncompliance by the employees identified above will be resolved in one or more of the following manners as may be deemed appropriate by the Privacy Officer:
 - additional or remedial privacy training;
 - counseling by a supervisor;
 - notation in personnel files;
 - letter of reprimand from the supervisor;
 - removal from within the firewall;
 - removal from current position;
 - suspension from current position;
 - termination of employment;
 - as otherwise deemed appropriate by the Privacy Officer.

Regardless of whether a person is disciplined or terminated pursuant to this provision, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

The privacy officer will keep a record of all disciplinary actions taken for six (6) years following the action.

The Plan will take all practical steps to reduce the harmful effects caused by uses or disclosures of PHI in violation of its policies or procedures and the HIPAA Privacy Rules.

NOTE: The above sanctions do not apply to violations that are disclosures by whistleblowers and work-force member crime victims or in the case of retaliatory or intimidating actions taken against individuals for asserting their privacy rights. Complaints about these actions will be directed to the Department of Health and Human Services Office of Civil Rights.

- Except as expressly listed herein or with specific written individual authorization, only summary information (information which has been de-identified) may be provided to the Sponsor /Employer.
- When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor /Employer will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purposes of the use or disclosure and will limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

HIPAA SECURITY STANDARDS

The Plan is compliant with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") having established Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on the later of April 21, 2005 (April 21, 2006 for small health plans).

I. Definitions

- A. Electronic Protected Health Information - The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
- B. Plan - The term "Plan" means the Plan as named above.
- C. Plan Documents - The term "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to the Hunt & Sons, Inc. Employee Benefit Plan.
- D. Security Incidents - The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

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

- A. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.
- B. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.
- C. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information.
- D. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - 2. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis monthly or more frequently upon the Plan's request.