

PLAN DOCUMENT AMENDMENT #1

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP DENTAL PLAN

EFFECTIVE JUNE 1, 2021

NOTICE IS HEREBY GIVEN that the University of the Incarnate Word Group Dental Plan document is amended effective June 1, 2021.

CHANGE 1. The first paragraph under the subsection “Eligible Dependent” which appears in the section entitled “HIGHLIGHTS OF THE GROUP DENTAL PLAN” is hereby deleted in its entirety and replaced with the following:

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term “Eligible Dependent” shall mean any one or more of the following, except that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

CHANGE 2. The subsection “Eligibility Restrictions,” which appears in the section entitled “PERSONS COVERED AND EFFECTIVE DATES” is hereby deleted in its entirety and replaced with the following:

Eligibility Restrictions

- You may not be covered under this Plan as both an employee and as a dependent.
- If both parents of a Child are Covered Employees, a Dependent Child can be covered under this Plan by either parent, but not by both parents.
- You may not enroll your dependents without enrolling yourself in the Plan.
- You and your dependents must enroll in the same plan option.

- Your dependent may not reside outside of the United States on a full-time basis. For purposes of the Plan, the United States includes U.S. territories.

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Group Dental Plan document amendment is hereby adopted in its entirety.

PLAN DOCUMENT AMENDMENT #2

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP DENTAL PLAN

EFFECTIVE JANUARY 1, 2023

NOTICE IS HEREBY GIVEN that the University of the Incarnate Word Group Dental Plan document is amended effective January 1, 2023.

CHANGE 1. As of the effective date of this amendment, wherever “Gilsbar, L.L.C.” appears in the Plan Document and Summary Plan Description as the Benefit Services Manager, it is replaced with “HealthComp Integrated Solutions, LLC.”

CHANGE 2. As of the effective date of this amendment, anywhere else the name “Gilsbar” or “Gilsbar, L.L.C.” appears in the Plan Document and Summary Plan Description, it is replaced with the name “HealthComp Integrated Solutions, LLC.”

CHANGE 3. As of the effective date of this amendment, wherever the website “www.myGilsbar.com” appears in the Plan Document and Summary Plan Description, it is replaced with “www.HCHealthBenefits.com.”

CHANGE 4. As of the effective date of this amendment, wherever the address appears in the Plan Document and Summary Plan Description as “P.O. Box 998 Covington, LA 70434”, it is hereby replaced with “P.O. Box 1590 Covington, LA 70434.”

Copies of the Plan document and this Plan document amendment are maintained on file by the Plan Administrator and by the Benefit Services Manager.

This Group Dental Plan document amendment is hereby adopted in its entirety.



**UNIVERSITY OF THE
INCARNATE WORD®**

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

FOR

UNIVERSITY OF THE INCARNATE WORD

GROUP DENTAL PLAN

**DOCUMENT CONTAINS CONFIDENTIAL PROPRIETARY
OR TRADE SECRET INFORMATION**

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UNIVERSITY OF THE INCARNATE WORD

GROUP DENTAL PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of the University of the Incarnate Word Group Dental Plan, which is a form of a Group Dental Plan sponsored and maintained by University of the Incarnate Word. The terms of this Summary Plan Description are effective as of June 1, 2018, and govern the administration and payment of claims incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the Plan.**

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HIGHLIGHTS OF THE GROUP DENTAL PLAN

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

Eligible Employee

The term “Eligible Employee” shall mean an employee who is regularly scheduled to work at least 30 hours a week for the Employer. An employee is not a temporary or leased employee or an independent contractor.

The Plan Administrator determines status as an Eligible Employee hereunder.

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term “Eligible Dependent” shall mean a legal United States resident who is one or more of the following. However, no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first.

A common law spouse is eligible for coverage under the Plan if the common law marriage is legally recognized in the jurisdiction in which the employee has his or her principal residence.

A domestic partner is not eligible for coverage under the Plan, even in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee who is:
 - a. under the age of 26; or
 - b. incapable of sustaining his or her own living due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained

covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals during the two years following the dependent's reaching limiting age, the Plan Administrator may require subsequent proof of the Child's disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

"Child" includes:

- a. a biological child; or
- b. a legally adopted child; or
- c. a child legally placed in the employee's home for the purpose of adoption by the employee;
or
- d. a stepchild; or
- e. a child of a covered common law Spouse; or
- f. a foster child; or
- g. a child under the legal guardianship of the employee;
- h. a grandchild if the child's parent is also a Covered Dependent or if the Covered Employee has legal custody of the child; or
- i. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

Eligibility Date

(See "Persons Covered and Effective Dates" section for enrollment details and effective dates.)

Employee: The first day of the month coinciding with or after you meet the Plan's definition of an Eligible Employee.

Dependent: The same as the employee's Eligibility Date if you have Eligible Dependents when you first become eligible to participate in the Plan.

Open Enrollment

(See “Persons Covered and Effective Dates” section for enrollment details.)

The Open Enrollment period is during the months of April and/or May. Coverage for a Participant enrolling during Open Enrollment is effective on the first day of June following enrollment.

Schedule of Dental Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Dental Benefits section for a description of covered expenses and benefit exclusions and limitations.

DEDUCTIBLES

DENTAL DEDUCTIBLE, PER CALENDAR YEAR (waived for Type I and Type IV expenses)	
Per Participant	\$50
Per Family	\$150

BENEFIT PERCENTAGES & MAXIMUMS

The Calendar Year maximum is for Types I, II and III benefits combined. The Lifetime maximum is for Type IV benefits only.

BENEFIT DESCRIPTION	PERCENTAGE PAYABLE	MAXIMUM BENEFIT	BENEFIT LIMITS FOR LATE ENROLLEES
Type I Preventative	100%, no deductible	\$1,500 Calendar Year maximum for Types I, II and III combined	None
Type II Basic Restorative	80% after deductible		No benefits for the first 12 months of coverage
Type III Major Restorative	80% after deductible		No benefits for the first 12 months of coverage
Type IV Orthodontics*	50%, no deductible	\$1,500 Lifetime maximum	No benefits for the first 12 months of coverage

*Orthodontics limited to Covered Dependent children to age 20.

DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily injury for which dental treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee's occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Allowable Charge: The Allowable Charge is the Reasonable and Customary amount; however, if the Plan Administrator secures a discount, the Allowable Charge will be the discounted amount.

Benefit Services Manager: Gilsbar, L.L.C., the entity that performs certain contracted nondiscretionary administrative services for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)

Eligible Employee: (See Highlights section.)

Employer: University of the Incarnate Word, including any affiliate or subsidiary thereof.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply which:

1. is not recognized by the state or national medical communities;
2. does not have final approval from the appropriate government regulatory bodies of the United States;
3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or
4. is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;
2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;
3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital as a registered bed patient and who is charged at least one day's room and board by the Hospital.

Late Enrollee: A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan or
2. during a Special Enrollment Period.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant's covered expenses, even if other provisions of the Plan appear to entitle the Participant to more. "Lifetime" shall mean while covered under this Plan or any other plan maintained by the Employer.

Marriage or Married: A union that is legally recognized as a Marriage under the state law where such Marriage was performed.

Medically Necessary or Medical Necessity: Describes dental treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;
2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;
3. Is not primarily Custodial Care; and
4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “medically necessary.” In addition, the fact that certain services are excluded from coverage under this Plan because they are not “medically necessary” does not mean that any other services are deemed to be “medically necessary.”

Medicare: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.

Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;
2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;
3. Provides at least two operating rooms and one post anesthesia recovery room;
4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;
5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;
6. Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Participant: Any Eligible Employee or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, covered person, and member have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and
2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: University of the Incarnate Word.

Plan Document: This Plan Document and Summary Plan Description.

Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Preferred Provider Organization or PPO: A network of providers offering discounted fees for services and supplies to Participants. The network will be identified on the Participant's Plan identification card.

Reasonable and Customary: Charges made for dental services or supplies essential to the care of the Participant will be considered Reasonable and Customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received. This may be established by the Plan Administrator by use of any customary or accepted method. In determining whether charges are Reasonable and Customary, the Plan Administrator will give due consideration to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill, or experience.

Routine Dental Exam: Exam by dentist not required because of Illness or Injury.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: An individual who is legally Married to a Covered Employee.

Summary Plan Description: This Plan Document and Summary Plan Description.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but is not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage

If you are eligible to become covered under the Plan as outlined in the Highlights section, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage

Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you choose not to enroll within 31 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 30 31 days of a special enrollment event described later in this section.

However, if you were covered under the prior plan when this Plan became effective, your Eligibility Date is the effective date of the Plan.

Your coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on your Eligibility Date, if you enroll within 31 days of becoming eligible; or
2. If you are a Late Enrollee, at 12:01 A.M. on the first day of June following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling during a Special Enrollment period, see the subsection below entitled "Special Enrollment Periods."

If you are not required to make a contribution to the cost of your coverage (that is, it is non-contributory), it is effective at 12:01 A.M. on your Eligibility Date. However, you must complete an enrollment form in order for your claims to be paid promptly.

If, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Effective Date of Dependent Coverage

Your dependents may be covered under the Plan only if you are a Covered Employee and if the dependents meet the Plan's requirements for Eligible Dependents. If you have Eligible Dependents when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is the same as your Eligibility Date. Any dependent not enrolled within 31 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 31 days of a special enrollment event described later in this section.

Dependent coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage within 31 days of becoming an Eligible Employee; or
2. If you or your dependent is a Late Enrollee, at 12:01 A.M. on the first day of June following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling your dependent during a Special Enrollment period, see the subsection below entitled "Special Enrollment Periods."

If dependent coverage is non-contributory, coverage is effective at 12:01 A.M. on the Eligibility Date. Your dependents must be listed on your enrollment form in order for claims to be paid promptly.

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Contributory coverage for a newborn child is effective on the date of birth only if application is made within 31 days after this date. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 31 days after this date. These are exceptions to provision (1) above.

Special Enrollment Periods

The employee must make a request for Special Enrollment to the Plan Administrator within 31 days of marriage, birth, adoption or the loss of other coverage (other than Medicaid or a State Children's Health Insurance Program). The request must be made in writing to the Plan Administrator.

Coverage is effective as follows:

1. For Marriage, the first day of the month following enrollment.

2. For loss of other coverage, the first day of the month following enrollment.
3. For birth or adoption, the date of birth or adoption, or the date the child is placed in the home for adoption.

Also see above subsections, “Effective Date of Employee Coverage” and “Effective Date of Dependent Coverage.”

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children’s Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for Special Enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

If an employee or a dependent does not enroll within 31 days of Marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee and may enroll only during the Open Enrollment Period.

Open Enrollment Period

The Open Enrollment Period and the corresponding coverage effective date are shown in the Highlights section. During the Open Enrollment Period only, the Plan allows an Eligible Employee (and/or his Eligible Dependents) who is not currently enrolled and who has completed any waiting period (i.e., a Late Enrollee) to elect coverage.

During the Open Enrollment period only, Eligible Employees who are currently enrolled may also elect to add or drop dependents, or drop coverage altogether.

Eligibility Restrictions

- You may not be covered under this Plan as both an employee and as a dependent.
- If both parents of a Child are Covered Employees, a Dependent Child can be covered under this Plan by either parent, but not by both parents.
- You may not enroll your dependents without enrolling yourself in the Plan.
- You must be a legal resident of the United States.

Change in Family Status

Once you are in the Plan, you must notify the Plan Administrator within 31 days of any family status change, such as a newborn baby, or when your first family member becomes eligible, or when you

no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.

Change in Coverage Status

If your coverage status changes from dependent to employee, or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Employees

When both you and your Spouse are Covered Employees and you have family coverage for dependent children, one Spouse will be treated as a dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Employees to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Court-ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a “medical child support order” (“MCSO”) or “national medical support notice” (“NMSN”) that is a “qualified medical child support order” (“QMCSO”) if the child named in the MCSO is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

“Alternate recipient” shall mean any child of a Covered Employee who is recognized under a MCSO as having a right to enrollment under this Plan as the Covered Employee’s Eligible Dependent. “MCSO” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee’s child or directs the Covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a Group Dental Plan.

“NMSN” shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s)); and
4. Identity of an underlying child support order.

“QMCSO” is an MCSO that creates or recognizes the existence of an Alternate Recipient’s right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

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

In addition, a NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “NMSN”;
 - a. 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; or
 - b. Informs the Plan Administrator that, if a Group Dental Plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and
2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving a MCSO, the Plan Administrator shall, as soon as administratively possible:

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

Upon receiving a NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - a. Whether the child is covered under the Plan; and
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

“GINA”

“GINA” shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits Group Dental Plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term “genetic information” means, with respect to any individual, information about:

1. Such individual’s genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

The term “genetic information” includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.

DENTAL BENEFITS

If you incur expenses for the covered dental services described below, the Plan will deduct the dental deductible from the amount of the total covered dental expenses and pay a percentage of the remainder, until the maximum benefit is reached for that service. Only one Calendar Year deductible per Participant applies to all types of services combined. The deductible, Calendar Year and Lifetime maximums, and benefit percentages for dental benefits are listed in the Schedule of Dental Benefits section of the Highlights.

Any portion of the Calendar Year deductible for 2018 satisfied under the plan of the Employer in effect immediately prior to the effective date of this Plan will be credited toward the 2018 Calendar Year deductible for this Plan.

A Participant's Calendar Year and Lifetime maximums under this Plan will be reduced by any amount paid for that Participant's expenses under the Employer's prior plan.

If you apply for dental coverage more than 31 days after the date you first became eligible (i.e. you are a Late Enrollee), your dental benefits will be limited as shown in the Schedule of Dental Benefits.

Covered Dental Expenses

Covered expenses include the Reasonable and Customary charges for the services described on the lists of covered services below, provided these expenses are:

1. For services that are essential for the necessary care of the teeth and performed by or under the direction of a licensed Dentist; and
2. Incurred by you or a dependent while covered by the dental provisions of this Plan.

An expense is incurred, for purposes of this section, on the date a service is performed or a supply is furnished, with the following exceptions, for which the expense will be deemed to be incurred as described:

1. For an appliance or modification of an appliance, on the date the master impression is made;
2. For a crown, a bridge, or an inlay or onlay restoration, on the date the tooth is prepared; and
3. For root canal therapy, on the date the pulp chamber of the tooth is opened.

If a service is listed under more than one type, the expenses for that service will be covered only under the listing for which you receive the greatest benefit.

Because many dental problems can be resolved in more than one way, the Plan Administrator reserves the right to determine the dental procedure codes as it deems appropriate that will represent the lowest-cost treatment which adequately restores the mouth to normal form and function. The codes used are based on nationally established standards of the dental profession.

Type I -- Preventive or Diagnostic Services

The following are covered expenses:

1. Initial/Periodic exam (limited to 2 per Calendar Year)
2. Bitewing X-ray (limited to 1 per Calendar Year)
3. Panoramic X-ray (limited to 1 per 3 Calendar Years, combined with full-mouth x-ray)
4. Full-mouth X-ray (limited to 1 per 3 Calendar Years, combined with panoramic x-ray)
5. Cephalometric film (see Type IV - Orthodontics)
6. Fluoride treatment (limited to 1 per Calendar Year; further limited to dependent Children up to age 16)
7. Non-routine visits (consultation and evaluation)
8. Pre-diagnostic detection of abnormal cells (ViziLite), (limited to 1 per Calendar Year)
9. Prophylaxis, (limited to 2 per Calendar Year)
10. Sealants, per tooth (limited to 1 per 3 Calendar Years; further limited to dependent Children up to age 16; further limited to permanent molars only)
11. Space maintainers (limited to 1 per Calendar Year; further limited to dependent Children up to age 16; further limited to initial appliances and all adjustments within six months after installation)

Type II -- Basic Services

The following are covered expenses:

1. Palliative treatment (for non-routine Emergency visits)
2. Non-routine visits (observation)

3. Crowns, stainless steel (limited to 1 replacement, if crown is unserviceable, per 8 Calendar Years)
4. Endodontics (root canals)
5. Extractions
6. Fillings, amalgam and resin-based composites
7. Occlusal adjustments (covered if in conjunction with periodontal surgery)
8. Occlusal guards for bruxism
9. Oral surgery (excluding surgical extraction of wisdom teeth)
10. Pulp tests
11. Periodontic scaling (limited to 1 scaling per quadrant per 2 Calendar Years)
12. Periodontic maintenance (limited to 2 per Calendar Year)
13. Periodontic surgery (limited to 1 per quadrant per 3 Calendar Years)
14. Full-mouth debridement (limited to 1 per Lifetime)
15. Splinting
16. Intravenous sedation or general anesthesia (covered only for dependent Children age 4 or younger, or for any Member if in connection with a surgical procedure)
17. Pin retention, filling
18. Antibiotic injections

Type III -- Major Restorative Services

The following are covered expenses:

1. Crowns, other than stainless steel (limited to 1 replacement, if crown is unserviceable, per 8 Calendar Years)

2. Post & Core, including pin retention (combine with charge for crown if done in connection with a crown)
3. Pontics (at least one tooth must have been extracted while covered under this Plan for the pontic to be covered; extraction of a third molar does not qualify)
4. Bridge (at least one tooth must have been extracted while covered under this Plan for the bridge to be covered; extraction of a third molar does not qualify)
5. Bridge replacements, if bridge is unserviceable (limited to 1 per 8 Calendar Years)
6. Denture, full or partial (at least one tooth must have been extracted while covered under this Plan for the denture to be covered; extraction of a third molar does not qualify)
7. Denture replacements, if denture is unserviceable (limited to 1 per 8 Calendar Years)
8. Rebase denture
9. Reline denture
10. Inlay/Onlay
11. Recementing of inlays/onlays
12. Tissue conditioning (not covered if within 6 months of initial placement of denture)
13. Veneers for the upper or lower anterior teeth (limited to 1 per 8 Calendar Years)

Type IV -- Orthodontic Services

The following are covered expenses:

1. Cephalometric film (if done for Orthodontics)
2. Orthodontic treatment for malocclusion, based on a written treatment plan submitted by the orthodontist within ninety (90) days before the start of treatment
3. Orthodontics are covered only for dependent Children up to age 20.

Dental Exclusions and Limitations

The following expenses are excluded from dental benefits:

1. Charges excluded under the General Exclusions and Limitations section of the Plan, unless stated otherwise.
2. Any service or supply covered in whole or in part under the medical provisions of this Plan.
3. Any service or treatment for Cosmetic purposes. The following are always considered to be for Cosmetic purposes:
 - a. facings on crowns or pontics posterior to the second bicuspid, and
 - b. personalization of dentures.

However, this exclusion does not apply to services required because of Injuries if:

- a. the services are rendered within six months after the Accident, and
 - b. the services are rendered while the person is covered for these dental benefits.
4. Replacement of a lost, missing or stolen prosthetic device or other device or appliance.
5. Appliances, restorations, or procedures for
 - a. altering of vertical dimensions, *
 - b. restoring or maintaining occlusion, *
 - c. correction of attrition or abrasion,
 - d. bite registration,
 - e. bite analysis, or
 - f. treatment of Temporomandibular Joint Syndrome (TMJ).

* By other than covered orthodontic treatment

6. Any service or supply not furnished by a dentist, except
 - a. a service performed by a dental hygienist working under the supervision of a dentist, and
 - b. X-ray order by a dentist.
7. Charges for plaque control programs or instruction in oral hygiene or diet.
8. Charges for dental implants.
9. Replacement within eight years of its last placement of any
 - a. prosthetic appliance,
 - b. crown,
 - c. inlay or onlay restoration, or
 - d. fixed bridge.

However, this exclusion does not apply to any such replacement required because of Injury.

10. Orthodontic services or dental care of a congenital or developmental malformation, unless included in the benefits for orthodontic services for certain Covered Dependent children.

GENERAL EXCLUSIONS AND LIMITATIONS

Note: See the Dental Benefit section for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description.

This Plan excludes or limits coverage as described for the following:

1. **Administrative fees,** interest or penalties.
2. **Claim filed late:** Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.
3. **Claim form:** Completion of a claim form.
4. **Complications from non-covered services:** Charges that result from complications arising from a non-covered illness or injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.
5. **Coordination of benefits:** Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.
6. **Cosmetic or Cosmetic Surgery:** Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:
 - a. incurred as a result of accidental injury;
 - b. for correction of a congenital anomaly.
7. **Coverage not in force:** Charges incurred while coverage is not in force under the Plan.
8. **Deductible:** Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.
9. **Excess of Reasonable and Customary:** That portion of any charge for any services or supplies in excess of the Reasonable and Customary charge, as determined by the Plan Administrator.
10. **Experimental or Investigational:** Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided.

11. **Family member:** Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.
12. **Government Plan:** Services or supplies furnished by or on behalf of the United States Government or any other government, are excluded unless, as to such other government, payment of the charge is legally required. Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.
13. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.
14. **Injury Due to Act of War:** Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.
15. **Not legally required to pay:** Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.
16. **Not listed:** Any items not listed as covered Expenses.
17. **Not necessary:** Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.
18. **Occupational Illness or Injury:** Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation.
19. **Oral statements:** Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.
20. **Personal** or convenience items.
21. **Prior to or after coverage:** Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.
22. **Prison:** Charges for services received while confined in a prison, jail or other penal institution.
23. **Sales tax** on prescription drugs or on any other covered items.

24. **Scheduled visit:** Failure to keep a scheduled dental visit.
25. **Telephone** conversations with a Physician or a Dentist.
26. Treatment of **Temporomandibular Joint syndrome**, whether surgical or nonsurgical.
27. **Unnecessary Services or Supplies:** Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.
28. **Violation of law:** The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.
29. **Vitamins**, minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a Physician, unless specifically covered herein.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a General Information Verification Form to verify continued eligibility for benefits. If you need a General Information Verification Form, you may download one from the Gilsbar web site at www.myGilsbar.com or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent has to go to the Hospital, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or Gilsbar's web site in advance. Sign the forms and send them to the Benefit Services Manager at the address listed on your ID card.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the patient's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to the Preferred Provider Organization, must be received by Gilsbar, L.L.C. no later than 365 days after the date the expense is Incurred. A claim received after this deadline will be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, L.L.C. to be sure the Claims Department has received all submitted claims.

CLAIMS PAYMENT AND APPEALS

Assignability

Benefits for Covered Expenses may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Claims Procedure

A description of the Plan's process for handling claims and appeals for health benefits follows. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan's procedures, which are described below. "Days" means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials: Pre-service Claim, Concurrent Claim, and Post-service Claim. The definitions and procedures for the three types of health claims are:

Pre-service Claim – a claim for a benefit under the Plan where prior approval for any part of the benefit is a condition to receiving the benefit. If a Participant makes a request for information on a charge or benefit (or a request for a determination of Medical Necessity) for which prior approval is not required by the Plan, that informational request or determination is not a pre-service claim. If a Participant needs medical care for a condition which could seriously jeopardize his life, health or ability to regain maximum function or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to seek or obtain approval in advance of obtaining medical care. The Participant should obtain such care without delay and contact the Utilization Management (UM) organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an ongoing course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated, or
2. the Participant requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require approval, then there is no need to contact the UM organization to request an extension of that treatment.

Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for approval is made and received by the UM organization or Benefit Services Manager in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant.

If the Plan contracts with a PPO network and you receive care through an in-network (PPO) provider, you will not need to file a medical claim. On your first visit to your network provider, you will sign a form to assign benefits to that provider, and they will file the claims on your behalf.

You will be responsible for filing your own claims if you use providers that do not participate in the PPO network, although some out-of-network providers may file claims on your behalf.

A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92 or successor forms, or an Electronic Data Interchange (EDI) file or other standard billing format;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee;
9. The name of the patient; and
10. Any Physician's notes, accident details, employment status, coordination of benefits information, or other information needed to adjudicate the claim.

When the information referenced above is provided, the claim is considered a "Clean Claim". The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If the claim is not a Clean Claim, the Plan may deny the claim or may take an extension of time in order to request additional information. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant or the authorized representative receives the request. **Failure to respond within this time period may result in claims being denied or reduced.**

“Adverse Benefit Determination” is defined as a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. It includes any reduction or failure to make payment resulting from the application of any utilization review, the application of any Plan exclusions, and the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

Timing of Notice of Benefit Determinations

Pre-service Claim:

1. If the Participant has provided all the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
2. If the Participant has not provided all the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).
3. If the Participant has failed to follow the Plan’s procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.
4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

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

2. Request by Participant for Extension of Treatment. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim or Post-service Claim and decided within the timeframe appropriate to that type of claim.

Post-service Claim:

1. If the Participant has provided all the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
2. If the Participant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.
3. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Form of Notice to Participant of Adverse Benefit Determinations

Once the claim has been decided, the Plan Administrator will provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

1. The reason or reasons for the Adverse Benefit Determination;
2. Reference to the Plan provisions on which the determination was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a denial of the appeal;
5. A statement that the Participant is entitled to request the diagnostic and treatment codes used and their meaning;
6. A statement that any rule, guideline, protocol, or criterion that was relied upon in making the Adverse Benefit determination will be provided free of charge to the Participant upon request;

7. If the denial is based on Medical Necessity, Experimental/Investigational Treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Procedure for Internal Appeals

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information will be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Participants; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant's responsibility to submit proof that the claim for benefits is covered and payable under the Plan's provisions. Any appeal must include the following:

1. The name of the Covered Employee/Participant;
2. The Covered Employee's/Participant's social security number or Participant ID number (PID);
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits, whether or not presented or available at the initial benefit decision. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the**

right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not rely on the initial Adverse Benefit Determination and will be conducted by an independent party who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Benefit Services Manager will consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice of determination. The notice will meet the requirements as described above.

The Plan Administrator will notify the Participant of the Plan's benefit determination on review within the following timeframes:

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

This Plan does not require prior approval for a Participant to receive urgent care; therefore, all urgent care claims will be handled as Concurrent or Post-service claims.

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

Responsibility for Deciding Claims and Appeals

The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the provisions in this section. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that

the Participant is entitled to them. Processing claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilsbar, L.L.C.

Decision on Appeal to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed and the decision on the appeal has been rendered by the Plan Administrator. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables

This chart of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section and applicable subsections carefully for complete information regarding the timetables that apply to your claim.

Time Limits	Type of Claim			
	Pre-Service	Concurrent: To end or reduce treatment prematurely	Concurrent: To deny your request to extend treatment	Post-Service
You'll be notified of determination as soon as possible, but no later than...	15 days from receipt of claim	Notification to end or reduce will allow time to finalize appeal before end of treatment	Treated as any other pre-service or post-service claim	30 days from receipt of claim
Extension period allowed for circumstances beyond the Benefit Services Manager's control...	15 days	n/a	Treated as any other pre-service or post-service claim	15 days
If additional information is needed, you must provide it within...	45 days of date of extension notice	n/a	Treated as any other pre-service or post-service claim	45 days of date of extension notice
You must file your appeal within...	180 days of claim denial	Denial letter will specify filing limit	Treated as any other pre-service or post-service claim	180 days of claim denial
You'll be notified of the appeal decision as soon as possible but no later than...	30 days from receipt of appeal	15 days from receipt of appeal	Treated as any other pre-service or post-service claim	60 days from receipt of appeal

Appointment of Authorized Representative

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

An Appointment of Authorized Representative Form may be obtained from www.myGilsbar.com or by calling the number below and forms must be submitted to:

Gilsbar, L.L.C.
Attention: Claims Dept.
P.O. Box 998
Covington, LA 70433
Phone: 1-888-472-4352
Fax: 985-898-1529

Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.

A covered person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare

guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of, Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

- a. The responsible party, its insurer, or any other source on behalf of that party,
- b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
- c. Any policy of insurance from any insurance company or guarantor of a third party,
- d. Workers' compensation or other liability insurance company,
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement,

judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

- a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- b. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- c. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft;
- d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) (Incurred) prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the

benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

- a. The responsible party, its insurer, or any other source on behalf of that party.
- b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- c. Any policy of insurance from any insurance company or guarantor of a third party.
- d. Workers' compensation or other liability insurance company.
- e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
- b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
- c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

- d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
- e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
- f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
- g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
- h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
- i. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
- j. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
- k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain

requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

COORDINATION WITH OTHER PLANS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed one hundred percent (100%) of the Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called "coordination of benefits." Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan provides for coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits as permitted by law.

As permitted by law, this Plan also will be the secondary payor and will coordinate its benefits with Medicare for Participants who are eligible to enroll in Medicare due to disability or End Stage Renal Disease (whether or not you are enrolled for such coverage). For Participants with End Stage Renal Disease, the Plan will pay the Allowable Charge for the first 90 days. After the first 90 days, the Plan will pay according to Medicare's published fee schedule.

For the purposes of this coordination provision, the term "plan" means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and
2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and college students. This does not include any law or plan where benefits are provided after those provided by other plans.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan (as described below) pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);
2. If a child is covered under both parents' plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:
 - a. the plan of the parent with custody of the child;
 - b. the plan of the Spouse of the parent with custody of the child;
 - c. the plan of the parent not having custody of the child; and
 - d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Allowable Charge shall be shared equally between the plans.

TERMINATION OF COVERAGE

Coverage will terminate for an employee at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;
2. Last day of the month in which employment terminates;
3. Date employee ceases to be an Eligible Employee for a reason other than termination of employment;
4. Date the employee chooses Medicare as his sole coverage;
5. The end of the last period for which any required contribution was received; or
6. Date of the employee's death; or
7. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;
2. Date the employee's coverage terminates;
3. Date the dependent enters active service with armed forces of any country;
4. Date the dependent ceases to be an Eligible Dependent (for any reason other than attaining the applicable age limit);
5. Date the dependent chooses Medicare as his sole coverage;
6. For a dependent Spouse, on the date of divorce or legal separation;
7. For a dependent child/children, the end of the month of attainment of the applicable age limit;
8. The end of the last period for which any required contribution was received; or

9. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

Reinstatement of Coverage

A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the employee is returning to work directly from the Plan's COBRA coverage, the waiting period will not apply provided he meets all the other requirements of the definition of an Eligible Employee. Participants whose coverage is reinstated under this provision will receive credit for any portion of the Calendar Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Continuation During Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your employer to see if COBRA applies to you and your dependents.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your

dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
3. Your Spouse's employment ends for any reason other than his or her gross misconduct;
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;
2. The parent-Covered Employee's hours of employment are reduced;
3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, or the Covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events

Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (210) 829-3847:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;
3. 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;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

University of the Incarnate Word
Plan Administrator
4301 Broadway, CPO 320
San Antonio, TX 78209
(210) 829-6019

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed) or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA

Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;
2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example attained limiting age);
7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event

properly is given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your employer ceases to provide a Group Dental Plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other Group Dental Plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Beneficiary who becomes covered under a Group Dental Plan which has a Pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a Pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election

period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

University of the Incarnate Word
Plan Administrator
4301 Broadway, CPO 320
San Antonio, TX 78209
(210) 829-6019

Current Addresses

In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and
2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and
3. You comply with the notice requirements set forth in “When will coverage continued through USERRA terminate?”

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?

The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;
2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?

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

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:
 - a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:
 - i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or
 - ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

- b. For leaves of 31 to 180 days, by submitting an application for reemployment with your Employer:
 - i. Not later than 14 days after completing uniformed service; or
 - ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.
- c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.
- d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your Employer.

PLAN ADMINISTRATION

The Plan Administrator

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Gilsbar, L.L.C., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator's relationship with Gilsbar, L.L.C. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

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

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and what charges are Reasonable and Customary), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a benefit services manager to pay claims;
9. To perform all necessary reporting as required;
10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

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

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

Expenses

All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.

Notices

All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity

In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

HIPAA PRIVACY

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as Required by Law (as defined in the Privacy Standards);
- Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or group employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Appropriate personnel designated by the Plan Administrator

- The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
- In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan Administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Effective April 20, 2005 (April 20, 2006 for small health plans as defined by 45 C.F.R. § 160.103), the following section will be added to the Plan. It is intended to bring the University of the Incarnate Word Group Dental Plan (“Plan”) into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the “HIPAA Security Standards”) by establishing Plan Sponsor’s obligations with respect to the security of Electronic Protected Health Information.

Accordingly, the following is hereby included in the Plan effective on the applicable date shown above:

1. Definitions

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.

Security Incident – The term “Security Incident” 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 system operations in an information system.

2. 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:

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

- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:
 - 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
 - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

OTHER INFORMATION

Plan Name	University of the Incarnate Word Group Dental Plan
SFP Number	S2855
State of Organization	University of the Incarnate Word is organized under the laws of the State of Texas.
Plan Sponsor	University of the Incarnate Word 4301 Broadway, CPO 320 San Antonio, TX 78209 (210) 829-6019
Tax Identification Number	74-1109661
Plan Administrator	University of the Incarnate Word 4301 Broadway, CPO 320 San Antonio, TX 78209 (210) 829-6019
Plan Affiliates/Subsidiaries	None
Benefit Services Manager	Gilsbar, L.L.C. P.O. Box 998 Covington, LA 70434 Telephone (985) 892-3520 or (800) 445-7227 Fax (985) 898-1500
Type of Plan and Administration	This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.
Plan Year Ends	May 31
Plan Cost	Employer shares the cost of employee and dependent coverage under this Plan with the Covered Employees. The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.

Benefits	Plan benefits are provided by University of the Incarnate Word.
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan is Not an Employment Contract	The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.
Effective Date	This Plan has been adopted by University of the Incarnate Word effective June 1, 2018.