PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

JAYNES COMPANIES

Dental PPO Plan
(Cigna Network)

EFFECTIVE DATE: January 1, 2024

RESTATEMENT DATE: January 1, 2025

TABLE OF CONTENTS

GENERAL PLAN INFORMATION

Type of Plan: The Plan is a self-funded employee welfare benefit plan.

Type of Administration: The administration of the Plan is provided through a Third-Party Claims Administrator. Plan benefits may be self-funded through a benefit fund, or a trust established by the Plan Sponsor and self-funded with contributions from Employees and/or the Plan Sponsor. The Plan is not insured.

Name of Plan: Jaynes Companies

Plan Year Ends: December 31

Employer Tax ID Number: 85-0172050

Group Number: H870613

Plan Number: 502

Employer Information
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

Participating Employers
Jaynes Corp.
Jaynes Structures
Jaynes Corp. of Colorado
Jaynes Corp. of Texas

Plan Sponsor/Plan Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

Named Fiduciary
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

Agent for Service of Legal Process
Matt Sanchez
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

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

Claims Administrator
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, Texas 75251
(972) 238-7900 or (800) 827-7223

The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

INTRODUCTION

The Plan Sponsor, identified in the General Plan Information section, sponsors the plan named Jaynes Companies ("Plan") for its eligible employees and dependents. This document is intended to serve as the plan document and, along with the separate premium information provided to you by the Plan Sponsor, is the Summary Plan Description (SPD) required by the Employee Retirement Income Security Act ("ERISA") for Plans subject to ERISA. The Plan Sponsor has contracted with Imagine360 to provide claims processing and other Plan administration services.

It is important that you review this document carefully as it describes Plan benefits and your rights and responsibilities under the Plan. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Reasonable Necessity, lack of timely filing of claims, or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

SCHEDULE OF DENTAL BENEFITS

All benefits described in this Plan Document are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Reasonably Necessary; charges are reasonable and customary; and services, supplies and care are not Experimental and/or Investigational. The meanings of capitalized terms are in the Definitions section of this document.

This document is intended to describe the dental benefits provided under the Plan but, due to the number and wide variety of different procedures and rapid changes in treatment standards, it is impossible to describe all Covered Dental Services and/or exclusions with specificity. Please contact the Claims Administrator regarding questions about specific supplies, treatments or procedures.

Dental PPO Plan		
Claims should be received by the Claims Administrator within 365 days from the date charges for the services were incurred. Benefits are based on the Plan's provisions in effect at the time the charges were incurred. Claims received later than that date will be denied. The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.		
DENTAL DEDUCTIBLE, PER CALENDAR YEAR		
Per Plan Participant	$50	
Per Family Unit	$150	
The Deductible is the dollar amount of Covered Dental Expenses for which you are responsible. A Deductible will be applied to the Covered Dental Expenses Incurred by each person covered under the Plan during each Calendar Year. The Family Unit Deductible is satisfied when 3 family members meet their Per Plan Participant Deductible amount.		
COINSURANCE	**Network**	**Non-Network**
Class A (Preventive) Services	100%, deductible waived	100%, deductible waived
Class B (Basic Restorative) Services	90%, deductible applies	80%, deductible applies
Class C (Major) Services	60%, deductible applies	50%, deductible applies
Class D Orthodontia Services	50%, deductible applies	50%, deductible applies
Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown above and is payable by the Plan Participant. Coinsurance *does not* apply to the deductible and *does not* include copayment amounts. Once the Plan has made the applicable benefit payment as shown in the Medical Benefits Schedule, the remaining percentage owed is the Plan Participant's "coinsurance" responsibility.		
MAXIMUM BENEFIT, PER CALENDAR YEAR		
Per Plan Participant - Class A, Class B, and Class C Services	$1,500	
MAXIMUM BENEFIT, PER LIFETIME		
Per Plan Participant – Orthodontia (up to age 19)	$2,000	

COVERED DENTAL SERVICES

The term Covered Dental Services refers to the items of dental expenses for which dental benefits may be payable.

Covered Dental Expenses are Reasonably Necessary services incurred for the following items of service and supply. A service or supply is considered Reasonably Necessary if it is: 1) appropriate and necessary as provided for the symptoms, diagnosis, or care and treatment of the dental condition, Injury, or Illness; 2) within standards of good dental practice in the organized dental community; 3) the most appropriate supply or level of service which can be safely provided; and 4) not primarily for the convenience of the Plan participant, or the Covered Provider.

A Covered Provider is an individual who is licensed to practice dentistry in the jurisdiction where such services are provided.

These charges are subject to the benefit limits, exclusions, and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the customary and reasonable amount for nonpreferred providers or the negotiated rate for preferred providers for covered dental expenses, as shown on the Schedule of Dental Benefits.

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

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

Class A Services:
Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If a dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- Oral Exams. Limit of two exams per Calendar Year.
- Cleanings (Prophylaxis). This includes the cleaning and scaling of teeth. Limit of two per Calendar Year.
- Emergency Palliative Treatment for pain.
- Fluoride Treatments (in conjunction with cleaning). For covered Dependent children up to age 18, limited to two times per Calendar Year.
- Sealants. For permanent molars only, once every 3 years. For Dependent children up to age 16.
- X-rays are covered as follows:
    - Full mouth once every 3 years.
    - Supplementary bitewings – twice per Calendar Year.
    - Supplementary periapical – two procedure per Calendar Year.
- Space maintainers used to maintain the present position of a tooth following an extraction. For covered Dependent children up to age 14.

Class B Services:
Basic Dental Procedures

Restorative

- Restoration of decayed teeth with amalgam, synthetics, or plastic, up to one restoration per surface. Composite restorations covered on all teeth.
- Repairs to restorations are allowed only once every 18 months, regardless of the reason.

NOTE: Tooth preparation, temporary restorations, cement bases, impressions, and local anesthesia are all considered part of the restoration and are covered only when included in the charge for the entire process.

General Anesthesia

- General anesthesia and IV sedation when administered by a dentist for a covered oral surgery procedure.

Endodontic Services

- Endondontic treatment, including root canal therapy. One pulp cap per tooth is allowed. Bases are not covered.

Periodontics

- Periodontic services are limited to one perio maintenance (two per Calendar Year in lieu of preventive cleaning);
- Root scaling and planing (once per quadrant of mouth in any 24 month period).
- Gingivectomy, gingival curettage.
- Osseous surgery including flap entry and closure.
- Pedical or free soft tissue grafts
- Full mouth debridement (one every five years).

Oral Surgery

- Extractions and other oral surgery involving procedures for simple and complicated extractions of impacted or erupted teeth, including frenectomy, alveolectomy, removal of palatal and mandibular tori, and crown exposure.

NOTE: Post-operative care and removal of sutures are considered part of the surgical procedure and are covered only when included in the charge for the entire surgical procedure.

Anesthesia Services
General anesthesia, including intravenous sedation, is limited to age seven and under, once per Calendar Year. General anesthesia for the extraction of impacted teeth for individuals age eight and over is covered based on necessity, not for anxiety management.

Class C Services:
Major Dental Procedures

Restorations

- Gold onlays and crowns are covered if teeth cannot be restored with amalgam, synthetic, porcelain, or plastic. Benefits are payable once every five years for the same tooth.

Prosthodontics

- Initial installation of a removable or fixed partial or complete denture once every five years. Fixed bridges for patients under age 16 are covered up to the amount allowed for a removable partial denture.
- One laboratory reline is covered following the initial installation of a denture and once every three years thereafter. Office relines are not a covered benefit.
- Replacement of missing teeth with complete or partial dentures or fixed bridges or implants is covered.
- Replacement of a denture or implant that is no longer serviceable is covered once every ten years.

Implant Services

- Implants are covered. Crowns associated with implants fall under the benefit for crowns.

Class D Services:
Orthodontia Services

Orthodontic Services

Orthodontic services are covered for functionally related problems, not for Cosmetic purposes, for eligible unmarried Dependent children ages seven through 19.

Initial diagnostic records (study models, facial photographs, etc.) are covered only if eligible orthodontic treatment is rendered.
Orthodontic treatment, including diagnostic procedures, X-rays, and appliance therapy.
Amounts paid under a previous dental care plan for a case in progress, which is defined as the placement of bands, will be deducted from the maximum amount payable for orthodontic benefits under this Plan.

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Covered Provider decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

DENTAL EXCLUSIONS

The following exclusions and limitations apply to expenses incurred by all Plan Participants. A charge for the following is not covered:

1. **Administrative costs**. Administrative costs of completing claim forms or reports or for providing dental records.

2. **Before coverage**. Care, treatment or supplies for which a charge was Incurred before a person was covered under this Plan.

3. **Broken appointments**. Charges for broken or missed dental appointments.

4. **Cosmetic.** Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.

5. **Dental transplants.** Dental transplants, reimplantations, and associated appliances or services rendered in conjunction with implants. This Exclusion does not apply to otherwise covered crowns.

6. **Error**. Care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

7. **Excess**. Care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the usual and customary amount, or are for services not deemed to be Reasonably Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

8. **Experimental**. Care, supplies, treatment and/or services that are Experimental or Investigational.

9. **Foreign services.** Care, treatment *or supplies performed outside the United States except for a Maximum Benefit of $100 for emergency dental Treatment performed outside the United States*.

10. **Government**. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

11. **Habit-breaking devices.** Habit-breaking devices or appliances to correct thumb sucking, tongue thrusting, etc.

12. **Hospital services.** Hospital services for dental procedures.

13. **Hygiene**. Oral hygiene, plaque control programs or dietary instructions.

14. **Illegal acts**. Care, supplies, treatment, and/or services for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

15. **Lab costs for an oral tissue biopsy.** Lab costs for an oral tissue biopsy.

16. **Myofunctional therapy**. Services for Myofunctional therapy.

17. **No charge**. Care and treatment for which there would not have been a charge if no coverage had been in force.

18. **No listing**. Services which are not included in the list of Covered Dental Services.

19. **No obligation to pay**. Charges Incurred for which the Plan has no legal obligation to pay.

20. **Not Medically or Dentally Necessary**. Care and treatment that is not Medically or Dentally Necessary.

21. **Occupational**. Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.

22. **Plan design**. Charges excluded or limited by the Plan design as stated in this document.

23. **Relative**. Professional services performed by a person who ordinarily resides in the Plan Participant's home or is related to the Plan Participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

24. **Replacement**. Replacement of lost or stolen appliances or prosthetic devices or duplicate appliances or prosthetic devices. Replacement of a prosthetic which in the Covered Provider's opinion can be repaired or does not need replacement.

25. **Restoration.** Restoration or replacing tooth structure lost as a result of abrasion or attrition.

26. **Self-inflicted**. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply (a) if the Injury resulted from being a victim of domestic violence or (b) resulted from a medical condition (including both physical and mental health conditions).

27. **Splinting**. Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

28. **Surgery.** Surgical services with respect to congenital or developmental malformations. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

29. **TMJ**. Any procedure or appliance to correct or treat temporomandibular joint dysfunction (TMJ).

30. **War**. Any loss that is due to a declared or undeclared act of war.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Eligible Classes of Employees.

All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage if he or she:

1. Is a full-time, Active Employee of the Employer. An Employee is considered to be full-time if the Employee is regularly scheduled to work at least 30 hours per week and is on the regular payroll of the Employer for that work.

   If the Employee is not designated as a full-time Active Employee by the Employer at the time of hire, the Employer may use a 12-month look-back measurement period to determine the full-time status as defined under the Plan. The Employee must average or be expected to average the required minimum hours of service during the Employee's initial 12-month measurement period to become eligible for coverage.

   An Employee's *initial measurement period* begins the first day of the month following the date of hire, with an initial stability period commencing the first day of the second full month following the initial measurement period. If there is a gap between the end of the Employee's first stability period and the start of the Employer's standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

   The Employer uses a *standard 12-month measurement period.* Coverage is effective the first day of the stability period following the applicable measurement period. To remain eligible for coverage, the Employee must average the required minimum hours of service during each subsequent standard measurement period.

   For more information on eligibility measurement periods, contact the Employer's Human Resources Department.

2. Is in an eligible class.

3. Is a board member who retires prior to age sixty-five (65). Board members and their Covered Dependents may remain on the Plan until the Board Member becomes eligible for Medicare.

Eligible Classes of Dependents. A "**Dependent**" is any one of the following persons:

1. A covered **Employee's Spouse.**

   The term "**Spouse**" shall mean the person to whom the covered Employee is legally married.

   This Plan does not allow coverage for common-law marriage.

   The Plan Administrator may require documentation proving a legal marriage.

   For Employees who reside in California, the term "Spouse" will also include "Domestic Partner," which shall mean a covered Employee's partner with whom a Domestic Partnership has been established and legally registered in the State of California, and any Employer required documentation has been received and accepted by the Employer.

2. A covered **Employee's Dependent child(ren).**

   A covered Employee's "**Dependent child**" includes natural child, Stepchild, adopted child, Domestic Partner's natural child, a child placed with the covered Employee in anticipation of adoption, a grandchild who resides in the Employee's household and is claimed as an exemption on the Employee's Federal income tax return, or children for whom the Employee or covered Spouse is Legal Guardian. A Dependent child will be eligible until reaching the limiting age of 26.

A “**Stepchild**” means a child of the Spouse who meets the eligibility requirements of this Plan for whom a covered Employee is the stepparent of the child(ren).

“**Legal Guardian**” means a person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

The phrase “**child placed with a covered Employee in anticipation of adoption**” refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term “placed” means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process has been initiated.

A child of a covered Employee who is an alternate recipient under a **Qualified Medical Child Support Order (QMCSO)** shall be considered as having a right to Dependent coverage under this Plan. A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

Please be advised, the definition of “Dependent” may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., non-IRC Section 152 dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

3. A **covered Dependent child who reaches the limiting age** and is 1) incapable of self-sustaining employment by reason of mental or physical handicap, 2) primarily dependent upon the covered Employee for support and maintenance, and 3) unmarried, can continue coverage under this Plan beyond the limiting age of 26. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof that the child is still Your dependent and qualifies for this coverage extension.

   After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

4. A covered Dependent spouse or Child of a board member remains eligible for the Plan until the board member becomes eligible for Medicare.

These persons are excluded as Dependents: Other individuals living in the covered Employee’s home, but who are not eligible as defined above; the divorced former Spouse of the Employee, former Domestic Partner of the Employee, foster child(ren), or any person who is covered under the Plan as an Employee.

If a Plan Participant covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the Plan Participant is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their children may be covered as Dependent children of one of the parents, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Please note that the Employee is solely responsible to notify the Plan when their dependent no longer qualifies as an eligible dependent for coverage under the Plan. Failure to timely notify the Plan may result in such Dependent's coverage being retroactively or prospectively terminated and a loss of Your Dependent's right to elect COBRA continuation coverage.

ACQUISITIONS

Employees who were enrolled under the health plan of an acquired company or in their eligibility waiting period, if applicable, as of the day before the date of acquisition, will be eligible to enroll themselves and their previously enrolled eligible Dependents for benefits under this Plan as of the date of acquisition, on the date of termination of the acquired company's benefit plan, or upon satisfaction of the eligibility waiting period, whichever is later. Any deductibles and maximum out-of-pocket amounts previously satisfied under the prior health plan will be applied toward the coverage under this Plan.

An acquired Employee (and their Dependents) who were not actively enrolled under the health plan offered by the acquired company, will not be eligible to enroll under this Plan until open enrollment or during a Special Enrollment event.

In the event that an acquired company did not have a health plan, all acquired Employees who otherwise meet the eligibility requirements of this Plan (and their eligible Dependents), will be eligible to enroll as of the date of the acquisition, subject to the eligibility waiting period.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the first month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.

2. The Active Employee Requirement.

3. The Enrollment Requirements of the Plan.

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing an enrollment application along with the appropriate payroll deduction authorization, if applicable. If Dependent coverage is desired, the covered Employee will be required to enroll the Dependent(s).

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee is automatically enrolled in this Plan for the first 31 days from the date of birth. In order to continue coverage beyond 31 days, the covered Employee must enroll the newborn child on a timely basis, as defined in the section "Timely Enrollment" following this section. If the covered Employee fails to enroll the newborn child on a timely basis, there will be no further payment from the Plan following the first 31 days from the date of birth.

TIMELY OR LATE ENROLLMENT AND OPEN ENROLLMENT

1. **Timely Enrollment** – The enrollment will be "timely" if the request for enrollment is received by the Plan Administrator no later *than the following*:

a. 31 days after the person *initially* becomes eligible for the coverage; or

b. 31 days after the person becomes eligible for the coverage under a “Loss of Other Coverage Special Enrollment Period”; or

c. 31 days after the person becomes eligible for the coverage under a “Acquiring a New Dependent Special Enrollment Period”.

If two Employees are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

2. **Late Enrollment** – An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their eligible Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

Unless otherwise required by law, if an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins as stated in the Open Enrollment section below.

3. **Open Enrollment** – Each year there is an annual open enrollment period designated by the Employer during which eligible Employees may enroll themselves and any eligible Dependents under the Plan or covered Employees may change their and their covered Dependents’ benefit elections under the Plan.

Benefit choices made during the open enrollment period will become effective January 1st.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

SPECIAL ENROLLMENT PERIODS

Federal law provides Special Enrollment provisions under some circumstances. The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

To request Special Enrollment or obtain more detailed information of these portability rules, contact the Plan Administrator.

1. **Losing other coverage may create a Special Enrollment right.** If an Employee is declining enrollment for themselves or their dependents because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and the loss of eligibility for coverage meets all of the following conditions:

a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual; and

b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment; and

c. Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as the result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated; and

d. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. If the request is timely made, coverage will begin the day following the date of the loss.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

i. The Employee or Dependent has a loss of eligibility due to the other plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

ii. The Employee or Dependent has a loss of eligibility under the other plan as a result of legal separation, divorce, termination of domestic partnership, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the Plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

iii. The Employee or Dependent has a loss of eligibility when the other coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

iv. The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

2. Acquiring a newly eligible Dependent may create a Special Enrollment right, if:

a. The Employee is a Participant under this Plan (or the Employee is eligible, but not enrolled in this Plan), and

b. A person becomes a Dependent of the Employee through marriage, domestic partnership, birth, adoption, or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for their eligible Dependents to enroll.

The Special Enrollment Period for newly eligible Dependents is a period of 31 days that begins after the date of the marriage, registration of domestic partnership, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this period.

In the case of birth, adoption, or placement for adoption, marriage and domestic partnerships, the Spouse/Dependents of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse/Dependent is otherwise eligible for coverage.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

a. in the case of marriage or domestic partnership, as of the date of marriage or registration of domestic partnership; or

b. in the case of a Dependent's birth, as of the date of birth; or

c. in the case of a Dependent's adoption or placement for adoption, as of the date of the adoption or placement for adoption; or

d. In the case of a Legal Guardianship, as of the date of Legal Guardianship appointment.

3. Medicaid or Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Employees and their Dependents who are otherwise eligible for coverage under the Plan, but who are not enrolled, can enroll in the Plan provided they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility if:

a. The Employee or Dependent cease to be eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage; or

b. The Employee or Dependent become newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Employee and/or Dependent may enroll under this Plan. If the Employee is not enrolled at the time of the event, he or she must enroll under this Special Enrollment Period in order for their eligible Dependent to enroll.

This Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan or on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. The effective date of coverage will be the first day of the first month following the date of loss of coverage or gain in eligibility.

If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer, and its Employees.

4. For Employees Participating in a Section 125 Plan

If you participate in a Section 125 plan, you may have an opportunity to make a change to coverage due to specific status changes in addition to the Special Enrollment Periods described above. Please refer to your Section 125 plan for additional information.

For more information regarding special enrollment periods, contact the Plan Administrator.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. **If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.** The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to recoup Plan payments by any method allowed by law.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated or amended such that the covered Employee loses coverage;

2. The last day of the month in which the covered Employee ceases to be in one of the Eligible Classes, or, if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of active employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability or leave of absence, unless the Plan specifically provides for continuation during these periods;

3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

4. As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Employee may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272 and the Company's Section 125 Plan and the Jaynes Companies Hour Bank Plan for California Employees.

Rehiring a Terminated Employee. A covered Employee who is terminated and rehired prior to the end of a 13 consecutive week period after the date of termination, will be eligible to re-enroll the first day of the first calendar month following the date of rehire.t Employees rehired after a break in service of 13-consecutive weeks or more will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Continuation During Family and Medical Leave. When applicable, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and its Employees covered by this Plan. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other applicable State leave law, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and their covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated.

Outside of FMLA, this Plan does not offer a continuation of coverage policy for an Employee and enrolled Dependents if the Employee's active, full-time work ceases.

NOTE: The Plan provides a four (4) month Leave of Absence for Pregnancy in accordance with California State Law that is concurrent with FMLA.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person under such an election shall be the lesser of:

    a. The 24-month period beginning on the date on which the person's absence begins; or

    b. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

2. A person who elects to continue group health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA Continuation Coverage requirements. Coverage elected under USERRA runs concurrently with COBRA. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

The Civilian Reservist Emergency Workforce Act of 2021 (“CREW”) provides eligible Employees, who are called to services by the Federal Emergency Management Agency (FEMA), rights under USERRA.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan or Dependent coverage under the Plan is terminated;

2. The date that the Employee's coverage under the Plan terminates. (See the section entitled COBRA Continuation Coverage.);

3. The last day of the month in which a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled COBRA Continuation Coverage.);

4. The last day of the month in which a Dependent child ceases to meet the applicable eligibility requirements. (See the section entitled COBRA Continuation Coverage.);

5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

6. As otherwise specified in the Eligibility section.

Note: Except in certain circumstances, a covered Dependent may be eligible for COBRA Continuation Coverage. For a complete explanation of when COBRA Continuation Coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage.

HOW TO SUBMIT A CLAIM

A “Claim” means a request for a Plan benefit made by a Claimant (the Plan Participant or an authorized representative) after dental treatment has occurred. When services are received from a health care provider, a Plan Participant should show their Group Health identification card to the provider. Providers may submit Claims on a Plan Participant’s behalf.

If it is necessary for a Plan Participant to submit a Claim, they should request an itemized bill from their health care provider which will include procedure (CPT) and diagnostic (ICD) codes.

The following information must be provided when submitting a Claim for processing:

- A copy of the itemized bill
- Group name and number (Jaynes Companies, Group H870613)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, and telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

WHEN CLAIMS SHOULD BE FILED

Claims should be received by the Claims Administrator within 365 days from the date charges for the services were Incurred. Benefits are based on the Plan's provisions in effect at the time the charges were Incurred. Claims received later than that date will be denied.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical/dental opinion.

WHERE TO SUBMIT CLAIMS

Claims for expenses should be submitted to the applicable address below:

NETWORK PROVIDER CLAIMS
Cigna
P.O. Box 188061
Chattanooga, TN 37422-8061
(866) 326-7849

ALL OTHER CLAIMS
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, TX 75251
(972) 238-7900 or (800) 827-7332

CLAIMS REVIEW PROCEDURES

A "Claim" means a request for a Plan benefit made by a Claimant (the Plan Participant or an authorized representative) after dental treatment has occurred. A Claim is not a request to determine a Claimant's eligibility for benefits, nor is it a request for a review prior to receiving dental treatment to determine Dental Necessity.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to a Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply by virtue of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives.

A "Post-Service Claim" is a Claim for dental care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were Incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical/dental knowledge or judgment.

Initial Benefit Determination

A Claim will not be deemed submitted until it is received by the Claims Administrator. The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.

If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45-day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide the Claimant with an Explanation of Benefits (EOB), and/or provide written or electronic notice of the determination to providers, that will include the following:

1. Information to identify the Claim involved.

2. Specific reason(s) for the denial, including the denial code and its meaning.

3. Reference to the specific Plan provisions on which the denial was based.

4. Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

5. Description of the Plan's Claims Review Procedures and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once the Claimant has exhausted all available review procedures.

6. Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

7. Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.

8. If the Adverse Benefit Determination is based on the Medical/Dental Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.

9. Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Explanation of Benefits/Explanation of Payment.

An Adverse Benefit Determination also includes a rescission of coverage when applied as a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, nor is it a retroactive cancellation or discontinuance due to the Plan Participant's failure to pay the required premium in a timely manner.

How to Appeal an Adverse Benefit Determination

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the person who made the determination on a prior level of review, nor a subordinate of that person.

In addition, the Plan Administrator may:

- Take into account all comments, documents, records, and other information submitted by the Claimant related to the Claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical/dental judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically/Dentally Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

First Level Claims Review

The written request for a First Level Claims Review must be submitted within 180 days of the Claimant's receipt of an Explanation of Benefits/Explanation of Payment that includes the adverse benefit determination.

The Claimant should include the following information in their request for review:

- Name of the covered Employee;
- Name and date of birth of the Plan Participant who Incurred the charges;
- Name of the Group Health plan and the identification number (as shown on the Group Health coverage ID card);
- A statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim;
- All facts and theories supporting the Claim for benefits. Failure to include any theories or facts in the appeal will result in such facts being inadmissible. In other words, the Claimant will lose the right to raise such factual arguments and theories which support this Claim if the Claimant fails to include them in the appeal;
- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
- Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

The First Level Claims Review request should be addressed to:

Plan Administrator
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, TX 75251
(972) 238-7900 or (800) 827-7332

An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of review if the Claimant fails to submit a timely request for a First Level Claims Review.

The First Level Claims Review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal. The Notice of Determination resulting from a First Level Claims Review shall meet the requirements as stated above.

Second Level Claims Review

If the Claimant does not agree with the determination from the First Level Claims Review, the Claimant may submit a Second Level Claims Review request in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level Claims Review, along with any additional supporting information.

The Second Level Claims Review request should be addressed to:

Plan Administrator
Imagine360 Administrators, LLC
Park Central 8
12770 Merit Drive, Suite 200
Dallas, TX 75251
(972) 238-7900 or (800) 827-7332

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot file suit if the Claimant fails to submit a timely appeal.

The Second Level Claims Review will be completed by the Plan Administrator and/or its designee. The Plan Administrator/designee will review the information initially received and any additional information provided by the Claimant and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator/designee will send a written or electronic Notice of Determination for the Second Level Claims Review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Claim Determination). The Second Level Claims Review Notice of Determination shall meet the requirements as stated above.

RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations, or exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Usual and Reasonable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, 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 other payers and/or the Plan Participant or dependent on whose behalf such payment was made, using any recovery method permitted by law.

A Plan Participant, dependent, 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 or refund 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. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any Claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor, to the extent allowed by law. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, 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-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. 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 the Plan must bring an action against a Plan Participant, provider, or other person or entity to enforce the provisions of this section, then that Plan Participant, provider, or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assignees (Plan Participants) shall assign, or be deemed to have assigned, to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to Facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Subrogation and Reimbursement Provisions; or
6. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any Claim for benefits under this Plan by a Plan Participant or by any of his covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a provider due to a Claim being made in error, a Claim being fraudulent on the part of the provider, and/or the Claim is the result of the provider's misstatement, said provider shall, as part of its Assignment of Benefits from the Plan, abstain from billing the Plan Participant for any outstanding amount(s).

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Dental Services when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Plan Participant is covered by this Plan and another plan, or the Plan Participant's Spouse (which is defined to include Domestic Partner, if applicable, in this section) is covered by this Plan and by another plan, or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plans involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Usual and Reasonable Charges.

Benefit plan. This provision will coordinate the medical and prescription drug and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or nongroup insurance contracts and subscriber contracts;

2. Uninsured arrangements of group or group-type coverage;

3. Group and nongroup coverage through closed panel plans;

4. Group-type contracts;

5. The medical components of long-term care contracts, such as skilled nursing care;

6. Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

7. The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;

8. Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured, or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident, or non-medical long-term care coverage.

Usual and Reasonable Charge(s). For a charge to be allowable, it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See "Usual and Reasonable Charge" in the Definitions section.)

In the case of Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Plan Participant does not use an HMO or network provider, this Plan will not consider as a Usual and Reasonable Charge any charge that would have been covered by the HMO or network plan had the Plan Participant used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Usual and Reasonable Charge.

Benefit plan payment order. When two or more plans provide benefits for the same Usual and Reasonable Charge, benefit payment will follow these rules:

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

2. Plans with a coordination provision will pay their benefits up to the Usual and Reasonable Charge.

The first rule that describes which plan is primary is the rule that applies:

a. The benefits of the plan which covers the person directly (that is, as an Employee, retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B"). For COBRA Qualified Beneficiaries, coordination is determined based on the person's status prior to the COBRA Qualifying Event.

   Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is Retired), THEN Plan B will pay first.

b. Unless there is a Medical Child Support Order stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan, the order of benefits is determined as follows:

   When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

   - The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
   - If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

   When a child's parents are divorced, legally separated, or not living together, whether or not they have ever been married, these rules will apply:

   - A Medical Child Support Order may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent's spouse does, the plan of that parent's spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree;
   - A Medical Child Support Order may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
   - If the specific terms of the Medical Child Support Order state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

   If there is no Medical Child Support Order allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

   1st The plan covering the custodial parent,
   2nd The plan covering the spouse of the custodial parent,
   3rd The plan covering the non-custodial parent, and
   4th The plan covering the spouse of the non-custodial parent.

   When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

   Unless specifically stated otherwise, Medical Child Support Order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, Rule (e) applies. If the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the birthday rule shall apply to the Dependent child's parents and the Dependent child's spouse.

c. The benefits of a benefit plan which covers a person as an Employee who is neither laid-off nor retired or as a Dependent of an Employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired Employee. This rule does not apply if Rule (a) can be used to determine the order of benefits. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

d. The benefits of a benefit plan which covers a person as an Employee who is neither laid-off nor retired or a Dependent of an Employee who is neither laid-off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (a) can be used to determine the order of benefits.

e. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Usual and Reasonable Charges when paying secondary.

f. a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

g. The Plan will pay primary to Tricare to the extent required by federal law.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Plan Participants who are eligible for Medicare benefits may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time. This Plan is primary to Medicare coverage for all active Employees and Dependents (regardless of age) unless Medicare states otherwise for certain medical conditions. In the event that this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by benefits that would be payable for the same services under Medicare Parts A and B, whether or not the Plan Participant is enrolled in Medicare Parts A and B.

Medicare Secondary Payer Rules

Medicare is the primary payor (and the Plan is the secondary payor) for:

1. Plan Participants with end stage renal disease (ESRD) beginning 30 months after the ESRD-based Medicare entitlement.

2. Plan Participants under age 65, who are covered by Medicare because of disability (other than ESRD), when the Plan Participant has coverage not due to current employment status (e.g., COBRA or retiree coverage) or the employer employs less than 100 employees.

If Medicare is the primary payor (and the Plan is the secondary payor), the benefits under the Plan are not intended to duplicate any benefits to which Plan Participants are, or would be, entitled under Medicare. Plan Participants must complete any documents or authorizations as may be requested by the Plan in order to obtain reimbursement by Medicare. The Plan will not reduce the benefits due to that Plan Participant's eligibility for Medicare where federal law requires that the Plan determine the benefits for that Plan Participant without regard to the benefits available under Medicare. This section will apply to the maximum extent permitted by federal or state law.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by the Plan Participant's State. Nationally, there are three types of State automobile insurance laws:

1. No-Fault Automobile Insurance laws;
2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

Coordination With Automobile No-fault Coverage. Except as required by law, the Plan is secondary to any No-Fault Automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a No-Fault Automobile Insurance policy nor does it intend to be primary in order to reduce the premiums or cost of No-Fault Automobile coverage.

If the Plan Participant or his/her covered Dependent incur Covered Dental Services as a result of an automobile Accident (either as driver, passenger, or pedestrian), the amount of Covered Dental Services that the Plan will pay is limited to:

1. Any deductible under the automobile coverage;
2. Any copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Dental Service; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

Coordination With Financial Responsibility Law. The Plan is secondary to automobile coverage or to any other party who may be liable for the Plan Participant's medical expenses resulting from the automobile Accident. If the Plan Participant's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile Accident for the Plan Participant or their Dependents.

Coordination With Other Automobile Liability Insurance. If the Plan Participant's State does not have a No-Fault Automobile Insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Plan Participant's medical expenses resulting from the automobile Accident.

Coordination With Underinsured/Uninsured Motorist Coverage. If the Plan Participant is involved in an automobile Accident and, as a result of the Accident, the Plan pays benefits, and if the Plan Participant receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Plan Participant of any recovery from their underinsured or uninsured motorist policy. The Plan Participant agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/ uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Plan Participant will give this Plan the information it asks for about other plans and their payment of Usual and Reasonable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator determines the Plan should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Plan Participant. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Usual and Reasonable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA (if applicable), the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Plan Participant under the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, Plan Beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assignees (collectively referred to hereafter in this section as "Plan Participant(s)") or a third party, where another party 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/dental payment provisions, third party assets, third party insurance and/or guarantor(s) of a third party (collectively "Coverage").

2. A Plan Participant(s), his/her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical/dental 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 Plan Participant(s) and/or his/her 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 Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits, the Plan 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 Plan Participant shall be a trustee over those Plan assets.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan 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 Plan 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 Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan 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 Plan expenses.

4. If there is more than one party responsible for charges paid by the Plan, or that 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, in regard to an unallocated settlement fund meant to compensate multiple injured parties of which the Plan 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

1. As a condition to participating in and receiving benefits under this Plan, the Plan 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 Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Plan Participant(s) fails to so pursue said rights and/or action.

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any Claim which any Plan Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Plan 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 Plan 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.

3. The Plan may, at its discretion, in its own name or in the name of the Plan 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.

4. If the Plan 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/dental 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; or
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages;

    then the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such Claims in the Plan Participant(s) and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such Claims. The Plan 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

1. 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 Plan 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 Plan 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 Plan Participant's/Plan 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 Plan Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Plan Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Plan 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.

2. 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.

3. 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 Plan 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.

4. 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 Plan Participant(s).

5. 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, or disability.

PARTICIPANT IS A TRUSTEE OVER PLAN ASSETS

1. Any Plan 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 Plan Participant understands that he/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/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 Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan 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; and
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.

2. To the extent the Plan Participant disputes this obligation to the Plan under this section, the Plan 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 attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Plan 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 Plan Participant(s) ("Incurred") prior to the liable party being released from liability. The Plan Participant's/Plan 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 Plan 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, Illness, 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:

1. The responsible party, its insurer, or any other source on behalf of that party;

2. Any first party insurance through medical/dental payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third party;

4. Workers' Compensation or other liability insurance company; or

5. 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 Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan 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 CLAIMS

In the event that the Plan Participant(s) dies as a result of his/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.

OBLIGATIONS

1. It is the Plan Participant(s) obligation at all times, both prior to and after payment of benefits by the Plan to:

a. 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. Provide the Plan with pertinent information regarding the Illness, disability, or Injury, including Accident reports, settlement information and any other requested additional information;
c. Take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d. Do nothing to prejudice the Plan's rights of subrogation and reimbursement;
e. Promptly reimburse the Plan when a recovery through settlement, judgment, award, or other payment is received;
f. Notify the Plan or its authorized representative of any incident related claims or care which may not be identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;
g. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
h. Not settle or release, without the prior consent of the Plan, any Claim to the extent that the Plan beneficiary may have against any responsible party or Coverage;
i. Instruct his/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 Plan Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Plan Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
k. Make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Plan Participant over settlement funds is resolved.

2. If the Plan 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 Plan 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 Plan Participant(s).

3. The Plan's right to reimbursement and/or subrogation is in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Plan Participant(s) 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 Plan Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) in an amount equivalent to any outstanding amounts owed by the Plan Participant to the Plan. This provision applies even if the Plan Participant has disbursed settlement funds.

MINOR STATUS

1. In the event the Plan 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/her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of 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. The Plan Sponsor 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.

RIGHT TO RECOVER BENEFITS PAID IN ERROR

The Plan has the right to recover any benefits the Plan paid in error to the Plan Participant or on behalf of a Plan Participant to which the Plan Participant is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's Usual and Reasonable Charges. The Plan may recover benefits paid in error from the Plan Participant, the provider who received a payment from the Plan on the Plan Participant's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Plan Participant's behalf, or from any other Plan Participant enrolled through the same covered Employee (or retiree, if applicable).

COBRA CONTINUATION COVERAGE

Introduction

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 and other members of Your family when group health coverage would otherwise end. You should check with Your Employer to see if COBRA applies to You and Your Dependents.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally doesn't accept Late Enrollees.

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." 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. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

Note: "Qualified Beneficiary" is a term defined under IRS COBRA regulations to mean a covered Employee, the spouse of a covered Employee, or the dependent child of a covered Employee. Continuation coverage for Domestic Partners and their dependents is offered voluntarily by the Employer and is not required by or subject to COBRA. As this is COBRA-equivalent coverage, a Domestic Partner will be treated as a Qualified Beneficiary to the same extent as if the Domestic Partner were the Employee's spouse and will have independent election rights, including in the event of the covered Employee's death. In addition, the dependent children of a covered Domestic Partner will be treated as "Qualified Beneficiaries" for these purposes to the same extent that dependents of a spouse would be so treated and will have independent election rights, including in the event of the covered Employee's death. Although the Plan will treat a Domestic Partner as a "Qualified Beneficiary," this treatment does not qualify a Domestic Partner as a "Qualified Beneficiary" under IRS COBRA final regulations.

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

If You are a covered Employee, You will become a Qualified Beneficiary if You lose Your coverage under the Plan due to one of the following Qualifying Events:

- Your hours of employment are reduced; or
- 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 due to one of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from Your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent – covered Employee dies;
- The parent – covered Employee's hours of employment are reduced;
- The parent – covered Employee's employment ends for any reason other than his or her gross misconduct;

- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the Plan as a "dependent child."

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan Administrator must be notified within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered, on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. 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 dependent children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual 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 is a temporary continuation of coverage that generally lasts for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If 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 can last for up to a total of 36 months.

Medicare extension of COBRA Continuation Coverage

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential 18-month COBRA continuation period for all Qualified Beneficiaries. While the covered Employee is only entitled to 18 months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or dependent children) are entitled to 18 months or 36 months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

Note: Medicare entitlement means that You are eligible for and enrolled in Medicare.

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 Social Security Administration (SSA) to be disabled and You notify the Plan Administrator as set forth herein, 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 will be charged for this extended COBRA Continuation Coverage.

Notice of the disability determination must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

- The date of the disability determination by the SSA;
- The date on which a Qualifying Event occurs;
- The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
- The date on which the Qualified Beneficiary is informed 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.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA's Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

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 the Plan Administrator is properly notified about the second Qualifying Event. 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 (in certain circumstances), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator by the date that is 60 days after the latest of:

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

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

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

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

- The date Your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules; or
- 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; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

How Do I Pay 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 are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA Continuation Coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if You don't enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period, You have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after Your employment ends; or
- The month after group health plan coverage based on current employment ends.

If You don't enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage.

If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if You are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-You.

Additional Information

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

Plan Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

COBRA Administrator
Jaynes Companies
2906 Broadway NE
Albuquerque, New Mexico 87107
(505) 345-8591

For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Current Addresses

To protect Your family's rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

To the extent required by ERISA to be prepared by the Plan, receive a summary of the Plan's annual financial report. Plan Administrators are required by law to furnish participants in certain plans with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

Continue health care coverage for Yourself, Your spouse and/or Your dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or Your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA Continuation Coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan Document or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for benefits which is denied or ignored, in whole or in part, You may file suit in a State or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a Medical Child Support Order, You may file suit in Federal court If it should happen that Plan fiduciaries misuse the Plan’s money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim or suit is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Office of Outreach, Education, and Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

The Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Privacy Rule, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending, or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Rule), and including quality assurance, Claims processing, auditing, and monitoring of the Plan.

3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law.

4. The Plan Sponsor must ensure that any agents, including subcontractors, 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 regard to the PHI.

5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.

7. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Document was amended as required by the HIPAA Privacy Rule.

8. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.

9. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.

10. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.

11. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.

12. The Plan Sponsor must, 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 information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.

13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time.

14. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan Document by persons described in paragraph 13 above through training, sanctions, and other disciplinary action, as necessary.

15. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

The Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 C.F.R. Sections 164.314(b)(1) and (2) and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending, or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

The Plan will disclose ePHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

2. The Plan Sponsor shall ensure the adequate separation that is required by 45 C.F.R. Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

3. The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.

    b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS

The Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a breach of unsecured Protected Health Information (PHI).

The Plan Sponsor will report to the Privacy Official of the Plan any use or disclosure of PHI not permitted by HIPAA, along with any breach of unsecured Protected Health Information. The Plan Sponsor will treat the breach as being discovered in accordance with HIPAA's requirements. The Plan Sponsor will make the report to the Privacy Official not more than 30 calendar days after the Plan Sponsor learns of such non-permitted use or disclosure. If a delay is

requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, the Plan Sponsor may delay notifying the Privacy Official for the time period specified by such regulation. The Plan Sponsor's report will at least:

1. Identify the nature of the breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any breach and the date of the discovery of any breach;

2. Identify Protected Health Information that was subject to the non-permitted use or disclosure or breach (such as whether full name, Social Security number, date of birth, home address, account number or other information was involved) on an individual-by-individual basis;

3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further breaches;

5. Identify what steps the individuals who were subject to a breach should take to protect themselves; and

6. Provide such other information, including a written report, as the Privacy Official may reasonably request.

The Plan Sponsor will report to the Privacy Official within 30 calendar days any attempted or successful: a) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and b) interference with the Plan Sponsor's system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware. The Plan Sponsor will make this report upon the Privacy Official's request, except if any such Security Incident resulted in a disclosure or Breach of Protected Health Information or Electronic Protected Health Information not permitted by the HITECH Act, the Plan Sponsor will make the report in accordance with the above.

GENERAL PROVISIONS

PLAN ADMINISTRATOR. Jaynes Companies is the benefit plan of Jaynes Companies, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA, if applicable. An individual or committee may be appointed by Jaynes Companies to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies, or is otherwise removed from the position, Jaynes Companies, shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall 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 shall 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, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

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 Plan Participant'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 third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA (if applicable);
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
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.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

MISSTATEMENT OF AGE

If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Plan Participant's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Benefits will be adjusted following the date of the discovery of such misstatement.

FUNDING

For Employee and Dependent Coverage: The Employer shares the cost of Employee and Dependent coverage under this Plan with the covered Employee.

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.

WAIVER OR ESTOPPEL

No term, condition, or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

UNCASHED CHECKS

A benefit payment made via check must be cashed or deposited within one year after the date the check was issued or it will be treated as a forfeiture and may be used by used the plan administrator to pay plan benefits or offset plan administrative expenses.

CONFORMITY WITH LAW

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation, or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation, or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay Claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

FRAUD

The following actions by a Plan Participant or a Plan Participant's knowledge of such actions being taken by another, constitute fraud and will result in termination of all coverage under this Plan for the entire family unit of which the Plan Participant is a member:

1. Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Plan Participant in the Plan;

2. Attempting to file a Claim for a Plan Participant for services that were not rendered or drugs or other items that were not provided;

3. Providing false or misleading information in connection with enrollment in the Plan; or

4. Providing any false or misleading information to the Plan.

In addition to being considered fraud on the Plan and an intentional misrepresentation, enrolling ineligible dependents, or maintaining coverage for a person who no longer satisfies the dependent eligibility rules violates company policy. If the company determines that an ineligible dependent has been enrolled, coverage may be canceled retroactively. The company reserves the right to recover any and all benefit payments made for services received by ineligible dependents and to terminate a Plan Participant's employment, if applicable.

ASSIGNMENT

A Plan Participant may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to an assignment of a Plan Participant's rights to the Plan or the Plan Administrator, or (2) to the extent required under Medicaid laws.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate the deductible amount to any Covered Dental Services and to apportion the benefits to the Plan Participant and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Plan Participant and all assignees.

FACILITY OF PAYMENT

If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or
2. A surviving relative (wife, husband, mother, father, child or children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part at any time and for any reason. This includes amending the benefits under the Plan or the Trust agreement (if any). Subject to the requirements of ERISA §402 (if applicable), in the event of a termination or partial termination of the Plan or Trust (if applicable), the rights of the Plan Participants are limited to expenses Incurred before termination and the Plan Sponsor shall direct the disposition of Plan assets, including assets held in a Trust, if any, which may include transfer of such assets to another employee benefit plan or trust maintained by the Plan Sponsor.

DEFINITIONS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Calendar Year means January 1st through December 31st of the same year.

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

Congenital Anomaly means a physical, metabolic, or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Dental Service(s) means those Dentally Necessary services or supplies that are covered under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Employee means a person who is classified by his Employer as an Active, common law Employee.

Employer is Jaynes Companies and affiliated companies, that together comprise a controlled group of companies as defined under IRC §§ 414(b) & (c).

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the Experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating Facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. except as provided under the Clinical Trial Benefits section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as dependents under the Plan.

Fiduciary means the Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Incurred means the date the 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 means an accidental physical Injury to the body caused by unexpected external means.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Plan Participant.

Medical Child Support Order means 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 Plan Participant's child or directs the Plan Participant to provide coverage under a health benefit 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 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medically or Dentally Necessary (Medical or Dental Necessity) means care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical/dental practice; is medically/dentally proven to be an effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical/dental services; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician/Dentist recommends or approves certain care does not mean that it is Medically/Dentally Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically/Dentally Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Physician means a Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Jaynes Companies, which is a benefits plan for certain Employees of Jaynes Companies and is described in this document.

Plan Amendment means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant is any Employee or dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the general level of charges made by most providers of like service in the same geographic area. This charge means an amount equivalent to the **90th percentile** of a commercially available database or such other database methodologies as may be available and adopted by the Plan. If there are no charges submitted for a given procedure, the Plan will determine a Usual and Reasonable Charge based upon charges made for similar services. Determination of the Usual and Reasonable Charge will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill, or experience.

In circumstances where a network arrangement or other discounting or negotiated arrangement exists, the Usual and Reasonable Charge means the contracted amount established by the network arrangement, or other discounting or negotiated arrangement with a provider. *The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.*

You/Your means the Employee and, when applicable, covered dependents.

Plan Name:	**Jaynes Companies**
Plan Option:	**Dental PPO Plan**
Effective:	**January 1, 2025**

I, Shad James (Name), certify that I am the President & CEO (Title) of the **Plan Administrator** for the above named Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the terms described herein and am hereby authorizing the implementation of the restated Plan as of the restatement date noted above.

Signature: _____

Print Name: Shade James

Date: 12/13/24