

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

**SOUTH TEXAS HEALTH
COOPERATIVE**

DENTAL PLAN

**SOUTH TEXAS HEALTH COOPERATIVE
EMPLOYEE DENTAL BENEFIT PLAN**

It is the intention of the Plan Sponsor, **South Texas Health Cooperative**, to hereby amend and restate the Employee Dental Benefit Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan".

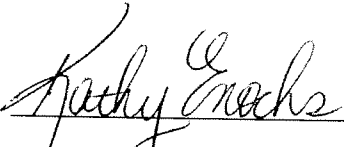
IN WITNESS WHEREOF, the Plan Sponsor has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

Original effective date of the Plan: **September 1, 2002**; Amended and restated effective: **September 1, 2005**



Date 1/17/06

For Plan Sponsor:
Anneliese McMinn, Co-op Board President
South Texas Health Cooperative



Date 1-19-06

For Claims Administrator:
Kathy Enochs, Chief Operating Officer
Group & Pension Administrators, Inc.

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GENERAL INFORMATION

This Plan Document describes the benefits for the Employees of **South Texas Health Cooperative**.

Name of the Plan

South Texas Health Cooperative Employee Dental Benefit Plan

Group to Which This Statement Applies

LaFeria Independent School District
Rio Hondo Independent School District
Lyford Consolidated Independent School District

Plan Sponsor

South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Plan Administrator

South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Type of Plan

Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process

Legal Process may also be served on the Plan Administrator

Anneliese McMinn, Co-op Board President
South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Claims Administrator

Group & Pension Administrators, Inc.
1500 N. Greenville Avenue, 4th Floor
Richardson, Texas 75081
972-238-7900 ♦ 800-827-7223

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

Plan Year

The twelve (12) month period beginning September 1 and ending August 31 of the next Calendar Year

Employer Tax ID Number

51-0555204

IRS Plan ID Number

501

INTRODUCTION

South Texas Health Cooperative, hereinafter referred to as "Co-op," hereby amends and restates the Employee Dental Benefit Plan, a self-funded Employee Welfare Benefit Plan hereinafter referred to as the "Plan" pursuant to which Plan benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

GENERAL AUTHORITY OF THE PLAN ADMINISTRATOR

Subject to the claims administration duties delegated to the Claim Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including, without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Plan will be interpreted by the Plan Administrator in accordance with the terms of the Plan and their intended meanings. However, the Plan Administrator shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion it deems to be appropriate in its sole judgment. The validity of any such finding of fact, interpretation, construction or decision shall be upheld in any legal action and shall be binding and conclusive on all interested parties unless clearly arbitrary and capricious.

To the extent the Plan Administrator has been granted discretionary authority under the Plan, the prior exercise of such authority by the Plan Administrator shall not obligate it to exercise its authority in a like fashion thereafter.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

ADMINISTRATION OF THE PLAN

The Plan Administrator has full charge of the operation and management of the Plan. The Plan Administrator has retained the services of the Claims Administrator, an independent claims processor experienced in claims review.

The Plan Administrator is the named fiduciary of the Plan except as noted herein. The Plan Administrator maintains discretionary authority to interpret the terms of the Plan, including but not limited to, determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect and shall be binding on all persons, unless it can be shown that the interpretation or determination was arbitrary and capricious.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Dental Expenses.

EFFECTIVE DATE

Original effective date of the Plan: **September 1, 2002**; Amended and restated effective: **September 1, 2005**

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information section.

NAMED FIDUCIARY

The named Fiduciary is **South Texas Health Cooperative**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Co-op may delegate responsibilities for the operation and administration of the Plan. The Co-op shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service providers, adjust their compensation (if any), and exercise general administrative authority over them. The Co-op has the sole authority and responsibility to review and make final decisions on all claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

The amount of contributions to the Plan are to be made on the following basis:

The Co-op shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Co-op's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Co-op's obligation with respect to such payments.

In the event that the Co-op terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

The Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a reasonable opportunity to any Plan Participant, whose claim for benefits has been denied, for a fair review of the decision denying the claim by the person designated by the Plan Administrator for that purpose. Details of the claims procedure are found in this Plan Document under the section entitled "Procedures for Claims and Appeals."

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any

payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

PLAN AMENDMENTS

This Document contains all the terms of the Plan and may be amended by the Plan Sponsor from time to time by a written resolution. Any such Plan Amendment shall become effective as of the date specified in the enabling resolution. A copy of any Plan Amendment shall be furnished to the Plan Administrator and any outside provider of plan administrative services.

MATERIAL MODIFICATIONS

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the modification or change. Covered Employee and beneficiaries must be furnished a Summary of such modifications or changes, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a Summary of Material Modifications or changes does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

TERMINATION OF PLAN

The Plan Sponsor reserves the right at any time to terminate the Plan or any benefit under the Plan by a written resolution to that effect. Previous contributions by the Employer and Employees shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

SCHEDULE OF DENTAL AND ORTHODONTIC BENEFITS

DENTAL PLAN I

(Dental Plan I is available to Employees of Rio Hondo ISD, LaFeria ISD and Lyford CISD)

Dental and Orthodontic Expense Benefits are separate from and in addition to the Medical Expense Benefits of this Plan. These benefits are available only if elected by an Eligible Employee for him/herself and Eligible Dependents.

MAXIMUM DENTAL BENEFIT

Benefit

Calendar Year Maximum Dental Benefit
(Preventive, Basic and Major Services)
Per Covered Person

\$1,000

Calendar Year Maximum Orthodontic Benefit
Per Covered Dependent Child

\$500

Lifetime Maximum Orthodontic Benefit
Per Covered Dependent Child

\$1,000

DENTAL CALENDAR YEAR DEDUCTIBLE

Per Covered Person
Family Member Limit

\$50
3 Family members

BENEFIT PERCENTAGE

Preventive Dental Services

100%; Deductible waived

Basic Dental Services

80% after Deductible

Major Dental Services

50% after Deductible

Orthodontic Services

50%; Deductible waived

Benefits limited to Dependent Children under age 19

DENTAL PLAN II

(Dental Plan II is available only to Employees of Lyford CISD)

Dental and Orthodontic Expense Benefits are separate from and in addition to the Medical Expense Benefits of this Plan. These benefits are available only if elected by an Eligible Employee for him/herself and Eligible Dependents.

MAXIMUM DENTAL BENEFIT	<u>Benefit</u>
Calendar Year Maximum Dental Benefit (Preventive, Basic and Major Services) Per Covered Person	\$1,000
Calendar Year Maximum Orthodontic Benefit Per Covered Dependent Child	\$500
Lifetime Maximum Orthodontic Benefit Per Covered Dependent Child	\$1,000
DENTAL CALENDAR YEAR DEDUCTIBLE	
Per Covered Person	\$50
Family Member Limit	3 Family members
BENEFIT PERCENTAGE	
Preventive Dental Services	80% after Deductible
Basic Dental Services	80% after Deductible
Major Dental Services	50% after Deductible
Orthodontic Services Benefits limited to Dependent Children under age 19	50%; Deductible waived

CALENDAR YEAR DEDUCTIBLE REQUIREMENT

The Covered Person is responsible for the Deductible amount. The Dental Calendar Year Deductible may be satisfied by Covered Preventive Dental Services (Plan II), Covered Basic Dental Services or Major Dental Services. Payment of Preventive, Basic and Major Dental benefits will begin each Calendar Year after the Deductible amount has been satisfied by Covered Charges. The Plan will not reimburse any charges applied to the Deductible.

There is no Deductible carry-over for Covered Dental Expenses incurred and applied to the Deductible during the last three (3) months of a Calendar Year.

DEDUCTIBLE FAMILY LIMIT

When three (3) covered Family members each satisfy the Dental Deductible in the same Calendar Year, no further Deductibles will be applied for any other Covered Family member for the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each Covered Family member can contribute no more than his/her own individual Deductible.

COVERED DENTAL SERVICES

Covered Dental Services shall not include any dental service not provided for in the Comprehensive Dental Expense Benefits and the Schedule of Dental and Orthodontic Benefits.

Expenses incurred for precision or semi-precision attachments, surgical implants of any type including any prosthetic device attached to them or instruction for plaque control or oral hygiene, bite registrations, splinting or dental services which do not have uniform professional endorsement will not be accepted nor considered as Covered Dental expenses.

NOTE: A temporary Dental Service will be considered an integral part of the final dental service rather than a separate service.

Dental services incurred in Mexico are covered, provided that:

- a. Treatment is necessary and recognized as usual treatment for that condition;
- b. Dental expenses are considered Usual and Customary according to the HIAA, based on the nearest U.S. geographical location to point of service;
- c. Procedures are approved by the ADA;
- d. All usual Plan provisions and limitations apply;
- e. Expenses must be filed in U.S. dollar amounts and must be translated into English; and
- f. Benefits may not be assigned to the Provider.

COMPREHENSIVE COVERED DENTAL EXPENSE BENEFITS

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES

Preventive

1. Dental Prophylaxis (cleaning and scaling of teeth):
Not more than two (2) such cleanings per Covered Person each Calendar Year.
2. Periodontal Prophylaxis
Not more than two (2) such cleanings per Covered Person each Calendar Year.
3. Fluoride Treatment (covered to age 19):
Not more than one (1) such treatment or series of treatment per Covered Person each Calendar Year.
 - a. Topical application of sodium fluoride - four treatments (excluding prophylaxis)
 - b. Topical application of stannous fluoride - one treatment (excluding prophylaxis)
 - c. Topical application of acid fluoride phosphate - one treatment (excluding prophylaxis)
4. Space Management Therapy (covered to age 16):
 - a. Fixed – unilateral and bilateral types
 - b. Removable - unilateral and bilateral types
 - c. Recementation of space maintainer

Diagnostic

Clinical Oral Examination (no other services rendered):

Not more than two (2) such examinations per Covered Person each Calendar Year.

1. Initial oral examination
2. Periodic oral examination

X-Rays

1. Bitewings - Not more than four (4) single films or two (2) series of films each Calendar Year
2. Intraoral periapical - single, first film
3. Intraoral periapical - each additional film
4. Intraoral - occlusal film
5. Extraoral - single, first film
6. Extraoral - each additional film
7. Posterior/anterior or lateral skull and facial bone survey film
8. Panoramic or Intraoral film - complete series (including bitewings) – Not more than once every thirty-six (36) months

Test and Laboratory Examinations

1. Caries susceptibility test
2. Pulp vitality tests
3. Bacteriological studies

Emergency Treatment

Palliative (emergency) exam and treatment of dental pain, minor procedures.

PREVENTIVE AND DIAGNOSTIC DENTAL SERVICES (CON'T.)

Removable Appliance Therapy

1. Occlusal guard – to minimize the effects of bruxism (grinding the teeth) – initial guard only (to age 16)
2. Removable/fixed appliance for harmful habits such as tongue thrust, thumbsucking – initial appliance only (to age 16)

BASIC DENTAL SERVICES

RESTORATIVE / ENDODONTICS / PERIODONTICS / PROSTHODONTICS / ORAL SURGERY

Restorative

1. Amalgam Restorations (including polishing):
 - a. Amalgam - one surface, deciduous
 - b. Amalgam - two surfaces, deciduous
 - c. Amalgam - three surfaces, deciduous
 - d. Amalgam - four or more surfaces, deciduous
 - e. Amalgam - one surface, permanent
 - f. Amalgam - two surfaces, permanent
 - g. Amalgam - three surfaces, permanent
 - h. Amalgam - four or more surfaces, permanent
 - i. Pin Retention - exclusive of amalgam
2. Silicate Cement per Restoration
3. Acrylic or Composite Restoration:
 - a. Acrylic
 - b. Composite resin - one surface
 - c. Composite resin - two surfaces
 - d. Composite resin - three surfaces
 - e. Pin retention - exclusive of composite resin
 - f. Composite resin (involving incisal angle)
4. Repairs and other Restorative Services:
 - a. Recement inlays/onlays
 - b. Recement crowns

Endodontics

1. Pulp Capping:
 - a. Pulp cap - direct (excluding final restoration)
 - b. Pulp cap - indirect (excluding final restoration)
2. Vital Pulpotomy (excluding final restoration)
3. Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care):
 - a. Anterior (excludes final restoration)
 - b. Bicuspid (excludes final restoration)
 - c. Molar (excludes final restoration)
4. Apicoectomy - performed as separate surgical procedure (per root)

Periodontics

1. Periodontal Evaluations
2. Surgical Services (including usual postoperative services):
 - a. Gingivectomy or gingivoplasty - per quadrant
 - b. Gingival curettage
 - c. Gingival flap procedure - per quadrant
 - d. Osseous surgery (including flap entry and closure) - per quadrant
 - e. Osseous graft - single site (including flap entry, closure, and donor site)
 - f. Osseous grafts - multiple sites (including flap entry, closure, and donor site)
 - g. Free soft tissue grafts (including donor site)
3. Adjunctive Periodontal Services:
 - a. Periodontal scaling and root planing (entire mouth)
 - b. Periodontal scaling and root planing (fewer than 12 teeth)

Prosthodontics, Removable-Adjustments, Repairs, Rebasing and Relining

1. Adjustments to Dentures:
 - a. Complete denture
 - b. Partial denture – upper
 - c. Partial denture – lower
2. Repairs to Dentures:
 - a. Repair broken complete or partial denture - no teeth damaged
 - b. Repair broken complete or partial denture - replace one broken tooth
 - c. Replace additional teeth - each tooth
 - d. Replace broken tooth on denture - no other repairs
 - e. Adding tooth to partial denture to replace extracted tooth
 - f. Reattaching damaged clasp or denture
 - g. Replacing broken clasp with new clasp on denture
 - h. Each additional clasp with rest
3. Denture Rebasing/Relining:
 - a. Rebasing/Relining upper or lower complete denture (office reline)
 - b. Rebasing/Relining upper or lower partial denture (office reline)
 - c. Relining upper or lower complete denture (laboratory)
 - d. Relining upper or lower partial denture (laboratory)
4. Tissue Conditioning

Prosthodontics, Fixed – Repairs and Other Services

1. Repairs to Bridges
2. Recement Bridgework or Dentures

Miscellaneous Services/Appliance(s)

1. Dental Consultations (required by the attending Dentist)
2. Occlusal adjustments
3. Nitrous oxide
4. Antibiotic injections by the attending Dentist

Oral Surgery

1. Extractions - includes local anesthesia and routine postoperative care:
 - a. Single tooth
 - b. Each additional tooth
2. Surgical Extractions - includes local anesthesia and routine postoperative care:
 - a. Extraction of tooth - erupted
 - b. Impaction that requires incision of overlying soft tissue and the removal of the tooth
 - c. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and the removal of the tooth
 - d. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone and sectioning of the tooth for removal
 - e. Root recovery (surgical removal of residual root)
3. Other Surgical Procedures:
 - a. Surgical exposure of impacted or unerupted tooth to aid eruption
 - b. Biopsy of oral tissue (hard)
 - c. Biopsy of oral tissue (soft)
 - d. Incision and drainage
4. Alveoloplasty (surgical preparation of ridge for dentures):
 - a. Per quadrant - in conjunction with extractions
 - b. Per quadrant - not in conjunction with extractions
5. Anesthesia:
 - a. General anesthesia (only when Medically Necessary and when administered in conjunction with oral or dental surgery)
 - b. IV sedation

Treatment of Temporomandibular Joint Dysfunctions

1. Diagnostic exam and x-rays
2. Physical medicine including ultrasound, diathermy, high voltage galvanic stimulation and transcutaneous nerve stimulation
3. Prescribed medication and injections
4. Appliance therapy including occlusal splints

MAJOR DENTAL SERVICES

RESTORATION & INSTALLATION OF PROSTHODONTICS

Restorative

1. Gold Foil Restorations:
 - a. Gold foil - one surface
 - b. Gold foil - two surfaces
 - c. Gold foil - three surfaces
2. Gold Inlay Restorations:
 - a. Inlay - gold, two surfaces
 - b. Inlay - gold, three surfaces
 - c. Onlay - per tooth (in addition to above)
3. Inlay - Porcelain
4. Crowns:
 - a. Plastic (acrylic)
 - b. Plastic - prefabricated
 - c. Plastic with gold
 - d. Plastic with nonprecious metal
 - e. Porcelain
 - f. Porcelain with gold
 - g. Porcelain with nonprecious metal
 - h. Gold (full cast)
 - i. Gold (3/4 cast)
 - j. Semi-precious metal (full cast)
 - k. Non-precious metal (full cast)
 - l. Crown buildups - pin retained
 - m. Cast post and core in addition to crown
 - n. Dowel pin-metal per tooth (in addition to abutment crown)
 - o. Crown lengthening
 - p. Stainless steel

Other Restorative Services

Prosthodontics – Removable – Fixed – Installation

1. Complete Dentures - including six (6) months post-delivery care:
 - a. Complete upper
 - b. Complete lower
 - c. Immediate upper
 - d. Immediate lower
2. Partial Dentures - including six (6) months post-delivery care:
 - a. Upper - without clasps, acrylic base
 - b. Lower - without clasps, acrylic base
 - c. Upper - with two gold clasps with rests, acrylic base
 - d. Lower - with two gold clasps with rests, acrylic base

- e. Lower - with gold lingual bar and two clasps, acrylic base
- f. Lower - with gold lingual bar and two clasps, cast base
- g. Upper - with gold palatal bar and two clasps, acrylic base
- h. Upper - with gold palatal bar and two gold clasps, cast base
- i. Removable unilateral partial denture one piece gold casting, clasp attachments, per unit including pontics
- j. Full cast partial - with two gold clasps (upper)
- k. Full cast partial - with two gold clasps (lower)

3. Additional Units for Partial Dentures:

- a. Each additional clasp with rest
- b. Each tooth (applies only to full cast partial)

4. Fixed Bridges (each abutment and each pontic constitutes a unit in a bridge)

5. Bridge Pontics:

- a. Cast gold
- b. Cast Nonprecious
- c. Slotted facing
- d. Slotted pontic
- e. Porcelain fused to gold
- f. Porcelain fused to nonprecious metal
- g. Plastic processed to gold
- h. Plastic processed to nonprecious metal

6. Retainers:

- a. Gold inlay - two surfaces
- b. Gold inlay - three or more surfaces
- c. Gold inlay - (onlaying cusps)

ORTHODONTIC SERVICES

Orthodontic Treatment

"Orthodontic treatment" means the movement of teeth through bone by means of active appliances when required to correct a malocclusion either:

1. Overbite or overjet of at least four millimeters
2. Maxillary and mandibular arches in either protrusive or retrusive relation of at least one cusp
3. Crossbite
4. Arch length discrepancy of more than four millimeters

Covered Orthodontic Services

1. Cephalometric X-rays - limited to one time in any two year period
2. Orthodontic Treatment - limited to malocclusions including:
 - a. Necessary services related to an active course of Orthodontic treatment.
 - b. Surgical exposure of impacted or unerupted tooth for Orthodontic reasons including wire attachment when indicated.
 - c. The initial and subsequent, if any, installation of Orthodontic appliances for an active course of Orthodontic treatment, including retainers and cervical traction appliances.
 - d. Adjustment of active Orthodontic appliances.
3. Study Models/Diagnostic casts - limited to one Study Model per Covered Person
4. Diagnostic photos

Date Incurred

A Covered Orthodontic Expense will be deemed incurred:

1. For cephalometric x-rays or study models - on the date the service was rendered
2. For all other expenses - on the date of insertion of bands or appliance

Orthodontic Treatment Plan

The Orthodontic Treatment Plan is the Dentist's report of recommended Orthodontic treatment on a form satisfactory to the Claims Administrator which:

1. Itemizes the Orthodontic procedures and charges required for correction of a malocclusion;
2. Lists the Usual Charges for each procedure; and
3. Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required.

When Coverage Begins

Benefits are payable for Covered Orthodontic Services incurred only after the Covered Person becomes effective under the terms of the Plan. Orthodontic benefits are available only to Covered Dependent children under the age of nineteen (19) years.

Orthodontic benefits are payable monthly over the course of treatment and cease upon termination of coverage.

GENERAL DENTAL PLAN LIMITATIONS AND EXCLUSIONS

All charges not specifically listed as Covered Charges are excluded. And in addition, no payment will be made under the Dental Plan for the following:

1. Charges in connection with an **Illness or Injury arising out of, or in the course of any employment for wage or profit.**
2. Charges in connection with an **Illness or Injury for which the covered individual is entitled to benefits under any Workers' Compensation** or similar Local, State or Federal Statute, or to the extent the covered individual is entitled to benefits or payments under Automobile Personal Injury Protection Insurance issued pursuant to any No-Fault type automobile reparations ordinance or statute.
3. Charges incurred in a **hospital owned or operated by the United States Government.**
4. Charges where **prohibited by law.**
5. Charges which you are **not legally required to pay** or for charges which would not have been made if no coverage existed.
6. Charges made which are **in excess of Usual and Customary (U&C) fees** or charges for unnecessary care or treatment.
7. Charges for **services and material received from a dental or medical department maintained by an employer**, a mutual benefit association, a labor union or a health and welfare fund.
8. Charges for services or supplies **furnished at the direction of the United States Government or any state**, province or other political subdivision, unless the covered individuals would be required to pay such charges in the absence of this coverage.
9. Charges for **dental appointments which are not kept.**
10. Charges for **any service or material not furnished by a Dentist**, except a service performed by a licensed dental hygienist under the direction of a Dentist or any x-ray ordered by the Dentist.
11. Charges for **facings on crowns or pontic, posterior to the second bicuspid.**
12. Personalization or **characterization of teeth or prosthetics.**
13. Claims received **after six (6) months from date of rendered service.**
14. Charges for services or treatment of **Illness or Injury incurred as a result of any act of war**, whether declared or undeclared or caused during service in the armed forces of any country or resulting from or sustained as a result of participation in a riot or civil insurrection.
15. Charges for or in connection with **care, treatment or operations, which are performed for cosmetic, elective or non-functional purposes**, unless such expenses are incurred as a result of an Accidental Injury. See #16.
16. Charges for treatment of **injuries incurred as the result of an Accidental Injury, which occurred prior to the effective date of coverage under this Plan.**
17. Charges for partial or full removable **dentures or fixed bridgework, or for the addition of one (1) or more teeth thereto, or for a crown or gold restoration if involving a replacement or modification of a denture, bridgework, crown or gold restoration** which was installed during the five (5) years immediately preceding such replacement or modification.

18. Charges for **partial or full removable dentures or fixed bridgework, involving replacement of one (1) or more natural teeth missing prior to the individual becoming covered under this Plan**, unless the denture or fixed bridgework also includes replacement of a natural tooth which is extracted while the individual is covered hereunder.
19. Charges for **rebasing/relining of partial or full removable dentures** for which like service was rendered within the two (2) years immediately preceding such rebasing/relining.
20. Charges for **replacement of broken or worn appliances or dentures or bridgework**, unless the Dentist certifies such equipment unserviceable and such equipment has been installed for a period of five (5) years.
21. **Records fee, chart fee and insurance filing fee.**
22. Charges for replacement of **lost or missing or stolen appliances or dentures or bridgework.**
23. Charges paid for Injuries or Illness incurred as a result of **illegal acts** involving violence or threat of violence to another person, or in which the Covered Person illegally uses a firearm, explosive or other weapon likely to cause physical harm or death unless such Injury is the result of a medical condition (either physical or mental) or an act of domestic violence.
24. Charges for necessary **Hospital services** when services are provided by a licensed Dentist or surgeon, while covered hereunder. Hospital charges, when Medically Necessary for a dental service, are covered by the Medical Plan.
25. Charges for professional dental treatment, surgical services and supplies provided by a **Close Relative** of the Covered Person, as defined in this Plan.
26. Charges for services to a Covered Person which involves an **appliance or modification of an appliance for which the impression was made before the individual became covered** hereunder, or a crown, bridge or gold restoration for which a tooth was prepared before the individual became covered hereunder, or root canal therapy for which the pulp chamber was opened before the individual became covered hereunder.
27. Charges for **certain drugs and medicines**, unless dispensed by a licensed pharmacist obtainable only by prescription.
28. Charges for **dental implants.**
29. Charges for **sealants, oral hygiene instructions**, dietary instructions, or a plaque control program, prescription fluoride, mouthwashes or topical oral solutions.
30. Charges for **Splinting**, unrelated to Temporomandibular Joint Dysfunction (TMJ).

In the event that more than one (1) Dentist furnishes services or materials for one (1) dental procedure, the Plan shall be liable for not more than its liability had one (1) Dentist furnished the services or materials.

DENTAL DEFINITIONS

Abutment: A tooth or root that retains or supports a fixed bridge or a removable prosthesis.

Acid Etch: The etching of a tooth with a mild acid to aid in the retention of composite filling material.

Acrylic: Plastic materials used in the fabrication of dentures and crowns and, occasionally, as a restorative filling material.

Amalgam: A metal alloy usually consisting of silver, tin, zinc and copper, combined with liquid pure mercury and used as restorative material in operative dentistry.

Anesthesia: Local – the condition produced by the administration of specific agents to achieve the loss of pain sensation in a specific location or area of the body; General – the condition produced by the administration of specific agents to render the patient completely unconscious and without pain sensation.

Appliance: A device used to provide function, therapeutic (healing) effect or space maintenance, or as an application of force to teeth to provide movement or growth changes, as in Orthodontics - Fixed – one that is attached to the teeth by cement or by adhesive materials and cannot be removed by the patient; Removable – one that can be taken in and out of the mouth by the patient; Prosthetic – one that is used to provide replacement for missing teeth.

Bitewing: A type of dental x-ray film that has a central tab or wing upon which the teeth close to hold the film in position. They are commonly called decay detecting x-rays because they show decay better than x-rays.

Bridgework or Prosthetic Appliance: Fixed – pontics or replacement teeth retained with crowns or inlays cemented to natural teeth and used as abutments; Fixed removable – one the Dentist can remove but the patient cannot; Removable – a partial denture, retained by attachments which permit removal of the denture, normally held by clasps.

Caries: A disease of progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

Composite: Tooth colored filling material primarily used in the anterior teeth.

Course of Treatment: A planned program of one or more services or supplies, whether rendered by one or more Dentists for the treatment of a dental condition diagnosed by the attending Dentist. A course of treatment begins on the date a Dentist first renders a service to correct or treat the diagnosed dental condition.

Crown: Natural crown – the portion of a tooth covered by enamel; artificial crown (cap) – restores the anatomy, function and esthetics of the natural crown.

Dental Hygienist: A person who has been trained and licensed to clean teeth and provide additional services and information on the prevention of oral disease and who works under the direct supervision of a Dentist.

Dentist: A Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.) who holds a lawful license authorizing the practice of dentistry in the locale where service is rendered.

Denture: A device replacing missing teeth. The term usually refers to full or partial dentures, but it actually means any substitute for missing natural teeth.

Endodontic Therapy: Treatment of diseases of the dental pulp and their canals: root canal therapy and pulp canal therapy.

Emergency Palliative Treatment: Any dental procedures necessary to alleviate (but not cure) acute pain or to temporarily alleviate (but not cure) conditions requiring the immediate attention of a Dentist to prevent irreparable harm to the Covered Person.

Fluoride: A solution of fluorine which is applied to the teeth for the purpose of preventing dental decay.

Frenectomy: Surgical cutting of any frenum, usually of the tongue.

Frenum: Muscle fibers covered by a mucous membrane that attaches the cheek, lips and/or tongue to associated dental mucosa.

Implant: A device surgically inserted into or onto the jaw bone that may support crown(s), a partial denture or complete denture, or used as an abutment for a fixed bridge.

Impression: A negative reproduction of a given area. It is made in order to produce a positive form or cast of the recorded teeth and/or soft tissues of the mouth.

Incurred Date:

- a. for an appliance or modification of an appliance, the date the impression is taken;
- b. for a crown, bridge or gold restoration, the date the tooth is prepared;
- c. for root canal therapy, the date the pulp chamber is opened; and
- d. for all other services, the date the service is provided.

Inlay: A restoration, usually of cast metals, made to fit a prepared tooth cavity and then cemented into place.

Malocclusion: An abnormal contact and/or position of the opposing teeth when brought together.

Occlusion: The contact relationship of the upper and lower teeth when brought together.

Onlay: A cast restoration that covers the entire chewing surface of the tooth.

Orthodontics: The branch of dentistry primarily concerned with the detection, prevention and correction of abnormalities in the positioning of the teeth in their relationship to the jaws.

Palliative: An alleviating measure used to relieve but not cure.

Partial Denture: A prosthesis replacing one or more, but less than all, of the natural teeth and associated structures. It may be removable or fixed and on one or both sides of the mouth.

Pedodontics: The specialty of children's dentistry.

Periodontics: The examination, diagnosis and treatment of diseases affecting the tissue surrounding and supporting the teeth.

Pontic: The part of a fixed bridge which is suspended between the abutments and which replaces a missing tooth or teeth.

Prophylaxis: The removal of tartar and stains from the teeth or the cleaning of the teeth by a Dentist or Dental Hygienist.

Prosthodontics: Dental specialty providing artificial replacement of one (1) or more natural teeth and/or the associated structure.

Rebase: A process of refitting a denture by the replacement of the entire denture-base material without changing the occlusal relations of the teeth.

Reline: To resurface the tissue-borne areas of a denture with new material.

Restoration: A broad term applied to any inlay, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

Root Canal Therapy: Complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals and filling the spaces with a sealing material.

Scaling: Removal of calculus (tartar) and stains from teeth with special instrument.

Sealant: A resinous agent applied to the grooves and pits of teeth to reduce decay.

Silicate: A relatively hard and translucent restorative material used primarily on the anterior teeth.

Splinting: Stabilizing or immobilizing teeth to gain strength and/or facilitate healing.

Topical: Painting the surface of teeth, as in fluoride treatment, or application of an anesthetic formula to the surface of the gum.

Temporomandibular Joint (TMJ): The connecting hinge mechanism between the base of the skull (temporal bone) and the lower jaw (mandible).

Temporomandibular Joint Dysfunction: Abnormal functioning of temporomandibular joint; also refers to symptoms arising in other areas secondary to the dysfunction.

Treatment Plan: A Dentist's report on a form satisfactory to the Claims Administrator which:

1. Itemizes the dental services recommended by the Dentist for the necessary dental care of a person;
2. Shows the Dentist's charge for each dental service; and
3. Is accompanied by supporting pre-operative x-ray or other diagnostic records where required or requested by the Claims Administrator.

Usual and Customary (U&C):

1. The Usual fee - the fee most frequently charged or accepted for covered dental care or supplies by a Dentist, Physician or Hospital; and
2. The Customary fee - the fee charged or accepted for covered dental care or supplies by those of similar professional standing in the same geographic area; "area" means a region large enough to determine a cross section of providers of dental care or supplies.

Vertical Dimension: The degree of jaw separation when the teeth are in contact.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Plan may pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed the benefits payable under this Plan had this Plan been primary. Only the amount paid by this Plan will be charged against the Plan Maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

For purposes of this Coordination of Benefits provision the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
 - a. Hospital indemnity benefits; and
 - b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including no fault automobile insurance on an individual basis.

The term "plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term "Allowable Expense" means any necessary item of expense, for which the charge is Usual and Customary, or is based on the contracted fee schedule of an alternate care delivery system, a portion of which is covered under at least one of the plans covering the person for whom the claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

The term "Claim Determination Period" means a Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom claim is made, has been covered under this Plan.

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the amount payable under this Plan had this Plan been primary during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or employee or as a dependent, under any other plan which has no provision similar in effect to this provision.
2. Dependents' benefits under this Plan who are also eligible for benefits:
 - a. As an insured person or employee under any other plan; or
 - b. As a dependent child of an insured person or employee covered under any other plan.
3. A Covered Person under this Plan who is also eligible for benefits as an insured person or employee under any other plan and has been covered continuously for a longer period of time under such other plan.

For the purpose of determining the applicability of and for implementing this provision, or any provision of similar purpose in any other plan, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information with respect to any person, which the Plan Administrator deems to be necessary for such purposes. Any Covered Person claiming benefits under this Plan will furnish to the Plan Administrator such information as may be necessary to implement this provision or to determine its applicability.

ORDER OF BENEFIT DETERMINATION

Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.
2. The plan which covers the Covered Person as an employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the claimant as a dependent.
3. If the Covered Person is a Dependent child:
 - a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
 - b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
 - c. If the plan with which this Plan is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.
4. If the Covered Person is a Dependent child and the parents are divorced, then:
 - a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
 - b. The plan of a step-parent with whom the child lives pays second (if applicable).
5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed paid under this Plan and to the extent of such payments, the Plan Administrator will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable Maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

COORDINATION WITH MEDICAL PLAN

In the event of duplicate coverage under the Co-op's Medical Plan and Dental Plan, the Medical Plan is Primary and pays first.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Covered Persons 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.

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 Covered Person'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 AUTO 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 Covered Person or their Covered Dependent incur Covered Charges as a result of an automobile accident (either as driver, passenger or pedestrian), the amount of Covered Charges 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 Charge; and
4. Any expense that the Plan is required to pay by law.

Any 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 Covered Person's medical expenses resulting from the automobile accident.

If Covered Person'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 Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person'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 Covered Person's medical expenses resulting from the automobile accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile accident and as a result of the accident, the Plan pays benefits and if the Covered Person receives a settlement from their uninsured or underinsured motorist policy, the Plan is entitled to receive from the proceeds of the settlement with the uninsured or underinsured 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 Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person 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.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. The Plan, in its sole discretion, may elect, but is not required, to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or the acts or omissions of Covered Persons or their dependants, beneficiaries, estate, heirs, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary"), where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds (collectively "Coverage") is available.
2. Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan's payment of medical benefits, to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits under the Plan, the Plan Beneficiary recognizes the property right or equitable interest of the Plan in any cause of action the Plan Beneficiary may have and the proceeds thereof.
3. In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to 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 Beneficiary is entitled, regardless of how classified or characterized. The Plan Beneficiary agrees to reimburse the Plan for any such benefits paid when judgment or settlement is made.
2. If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any third party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.
3. If the Plan Beneficiary decides to pursue a third party or any Coverage available as a result of the said injury or condition, the Plan Beneficiary agrees to include the Plan's subrogation claim in that action. If there is a failure to do so, the Plan will be legally presumed to be included in such action.
4. The Plan may in its own name or in the name of the Plan Beneficiary or his/her personal representative, commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.
5. If the Plan Beneficiary fails to file a claim or pursue damages against:
 - a. the responsible party, its insurer, or any other source on behalf of that party;
 - b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. any policy of insurance from any insurance company or guarantor of a third party;
 - d. worker's 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 Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, and without regard to whether the Plan Beneficiary is fully compensated by his/her net recovery from all sources. The obligation 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. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. The Plan's equitable subrogation lien specifically supersedes all common law or statutory rules and doctrines such as the "make whole doctrine," the "common fund doctrine," and the law of any state prohibiting any assignment of rights, which interferes with or compromises in any way the Plan's equitable subrogation lien.
3. The Plan will not be responsible for any expenses, attorney's fees, costs, or other monies incurred by the attorney for the Plan Beneficiary or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
4. 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 Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any so called "lien reduction statutes" which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason, will not be applicable to the Plan and will not reduce the Plan's subrogation recovery.
5. 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 Beneficiary.
6. 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 sickness, injury, disease or disability.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available (based on information known or provided to the Plan, or to the Plan Beneficiary) any other 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. The Plan's benefits shall be excess to:

- a. the responsible party, its insurer, or any other source on behalf of that party;
- b. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c. any policy of insurance from any insurance company or guarantor of a third party;
- d. worker's 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;

WRONGFUL DEATH CLAIMS

In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights still apply.

OBLIGATIONS

1. It is the Plan Beneficiary's obligation:
 - a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in trial in order to preserve the Plan's subrogation rights;
 - b. to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. to not settle or release, without the prior consent of the Plan, any claim that the Plan Beneficiary may have against any legally responsible party or Coverage to the extent the Plan is or may be entitled to any part of such settlement proceeds.
2. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld to satisfy the Plan Beneficiary's obligation. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary 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 Beneficiary.

MINOR STATUS

1. In the event the Plan Beneficiary 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 requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at anytime 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.

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. Claims **must** be filed within six (6) months from the date of service to be covered by the Plan. If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within six (6) months from the date of service, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims incurred prior to the Plan termination **must** be received within ninety (90) days after the termination, or the Claims will not be covered.

Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

There are four types of claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A "Pre-service Claim" is a Claim for a benefit under the Plan, where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on a urgent or non-urgent basis, there are no "Pre-service Claims." The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.
- A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact the Utilization Review Company to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.
- A "Post-service Claim" is a Claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number, and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including any PPO repricing information);
6. The name of the Plan;
7. The name of the Covered Employee; and
8. The name of the patient.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred, or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under the Plan.

CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

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

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;
2. References to the Plan provisions on which the Adverse Benefit Determination is based;
3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's Claim;
6. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);
7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and
8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary, while a claim is pending. Benefits are payable under this Plan, only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a UR to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges, and (c) charges beyond the reasonable, necessary, and U&C guidelines as determined by the Plan.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care provider rendering such services. Such payment to a health care provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment; the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.
2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.
3. The Claimant will be provided, on request and free of charge, reasonable access to, and copies of (a) all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.
4. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

5. No deference will be afforded to the previous Adverse Benefit Determination.
6. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.
7. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Claims Administrator or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.
8. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.
9. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be decided within thirty (30) days of the Plan's receipt of the request.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within 180 days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

Appeals Department
Group & Pension Administrators, Inc.
1500 N. Greenville, 4th Floor
Richardson, TX 75081

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. 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;**
5. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim; and
6. Any material or information that the Claimant has, which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal

The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;
2. References to the Plan provisions on which the Adverse Benefit Determination is based;
3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;
4. A 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 Claimant's Claim;
5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;
6. A description of voluntary appeal procedures offered by the Plan and, upon Claimant's request, any additional information about the voluntary appeal procedures;
7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;
8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;
9. The identity of any medical or vocational experts consulted in connection with the Claim, even if, the Plan did not rely upon their advice; and
10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal: Requirements for Second Appeal

Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has 60 days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal

The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three years after the Plan's claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within three years after the date of service.**

Appointment of Authorized Representative

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

GENERAL PROVISIONS

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to allowable expenses in excess of the Maximum amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the Covered Person's true 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 Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

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.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan, which is in conflict with statutes that are applicable to this Plan, is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES

All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date post-marked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

STATEMENTS

Any fraudulent statements or misrepresentations made by a Covered Person or a Covered Person's representative in connection with Plan eligibility and/or Plan benefits may, as determined by the Plan Sponsor in its discretion, void Plan benefits or be used in defense to a claim for eligibility under the Plan and/or for such Plan benefits.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of this Plan.

ASSIGNMENT

The benefits provided under this Plan shall not be assignable without the consent of the Plan Administrator. The Employee may authorize the Plan Administrator to pay benefits directly to the Hospital, Physician or other party providing medical treatment. Any such payment will discharge the Plan to the extent of payment made. Unless permitted by law, payments may not be attached, nor be subject to the Employee's debts.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan reserves the right to allocate the Deductible amount to any Covered Charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person 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 (spouse, parent or child).

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

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

Effective April 14, 2004, 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 Standards of the Health Insurance and Portability Act of 1996 (the "HIPAA Privacy 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 Privacy 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 PROTECTED HEALTH INFORMATION (PHI)

Effective April 14, 2004, 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 Standards), 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 documents or 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 Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.
8. 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.
9. 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.
10. 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.
11. 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.
12. 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 in various Business Associate Agreements between the Plan and the Plan's Business Associates or in other documents governing the administration of the Plan.
13. 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 12 above through training, sanctions and other disciplinary action, as necessary.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

Effective April 20, 2006, 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 and Portability 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)

Effective April 20, 2006, the Plan will disclose ePHI to the Plan Sponsor only upon receipt of an amendment to the Plan 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 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.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan Document as follows.

EMPLOYEE ELIGIBILITY

An Employee will be considered eligible for coverage on the first day of the month following the Date of Hire provided he/she: Is regularly scheduled to work for the Employer on a Full-time Employment basis for at least twenty (20) hours per week. This requirement is suspended during any member district sponsored holiday period as long as the Employee is within their contract period.

DEPENDENT ELIGIBILITY

A Dependent, as defined in the Plan Definitions, will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage or the date the Dependent is acquired, subject to all limitations and requirements of this Plan, and in accordance with the following:

- 1. For Employees with coverage for Dependent children in effect:** A newborn child of a Covered Employee will be considered eligible and will be covered from the moment of birth for thirty-one (31) days for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, Routine Newborn Care and Well Baby Care. Written notification must be received by the Plan Administrator within thirty-one (31) days after the child's date of birth for continued coverage. A newborn of a Dependent child is not eligible for this Plan unless the newborn child meets the definition of an Eligible Dependent.
- 2. For Employees with no coverage for Dependent children in effect:** A newborn child of a Covered Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, Routine Newborn Care and Well Baby Care **if written notification to add the child is received by the Plan Administrator within thirty-one (31) days following the child's date of birth.** If written notification to add a newborn child is received by the Plan Administrator AFTER the thirty-one (31) day period immediately following the child's date of birth, the child is considered a Late Enrollee and not eligible for the Plan until the next Annual Open Enrollment Period. A newborn child of a Dependent child is not eligible for this Plan unless the newborn child meets the definition of an Eligible Dependent.
- 3.** A new spouse of a Covered Employee and any dependent children of a new spouse who meet the Plan's definition of "Dependent" will be considered eligible and will be covered on the date of the Covered Employee's marriage, provided the spouse and/or his/her children are enrolled as Dependents of the Covered Employee within thirty-one (31) days after the date of marriage.
- 4.** A child under the age of eighteen (18) placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child.
- 5.** A child of a non-custodial parent, who is a Covered Employee or an Eligible Employee will be considered eligible if the Employee is required to provide benefit coverage for the child in accordance with applicable requirements of a Qualified Medical Child Support Order (QMCSO).
- 6.** A Dependent child will be considered eligible if child is unmarried, under the age of twenty-five (25) years and primarily dependent upon the Covered Employee for support.

7. If a Dependent of a Covered Employee is to be enrolled in the Plan, other than at the time of his/her eligibility or birth, adoption, court order or marriage to the Covered Employee, that Dependent would be considered a Late Enrollee unless he/she qualifies for a Special Enrollment.
8. A spouse and/or child of a Covered Employee who previously was not eligible for the Plan will be considered eligible on the date he/she meets the Plan's definition of "Dependent."

The Eligibility provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) effective August 10, 1993 as the same may be later amended.

If an Employee or Dependent has a change in eligibility while covered under this Plan (i.e., from Employee to Dependent, from Dependent to Employee) and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous with respect to the Pre-existing Condition Exclusion Limitation and Eligibility Waiting Period.

If both the husband and wife are employed by the Co-op, and both have Dependent(s) eligible for coverage, either the husband or wife, but not both, may elect Dependent coverage for their eligible Dependents.

NOTE: A Dependent, who was enrolled on the most recent restated date of this Plan and who was previously covered by this Plan and met the Plan's prior definition of Dependent, is also considered eligible to continue coverage subject to the terms and conditions of this Plan.

TRANSFERS

If an Employee terminates employment with a participating Co-op school district and is hired as an Employee under one of the other participating Co-op school districts, coverage for the Employee and/or any covered Dependents will continue as usual as long as there is NO GAP in coverage. Proper enrollment forms must be completed with the new Employer (school district) in order to identify the Employee with the appropriate Employer (school district).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS/PLACEMENT FOR ADOPTION

The Plan will comply with the rules relating to adopted children, children placed for adoption, Qualified Medical Child Support Orders ("QMCSO"), and National Medical Support Notices ("NMSN"). The Plan will use the following rules related to children placed for adoption, QMCSOs and NMSNs.

This Plan will provide benefits in accordance with the applicable requirements of any QMCSO or NMSN. A QMCSO is a medical child support order of a court or of certain administrative agencies that creates, recognizes or assigns to a child of an Employee the right to receive health benefit coverage under the Plan. A NMSN is an order issued by a state agency requiring the Plan to cover a child. To be qualified, a medical child support order must comply with state and federal laws and contain the following:

1. The name and last known mailing address (if any) of both the Employee and the child covered under the order except that, to the extent provided in the order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient.
2. A reasonable description of the type of coverage to be provided by the Plan for each child (or the manner in which the type of coverage will be determined).
3. The period of coverage to which the order applies.

In addition, a QMCSO or NMSN will generally not be considered qualified if it requires the Plan to provide certain benefits or options which are not otherwise provided by the Plan. The Plan Administrator will notify the Employee of the receipt of a medical child support order and the procedures for determining whether it is a Qualified Medical Child Support Order or a NMSN. The Plan Administrator will then determine within a reasonable period of time whether the medical child support is a QMCSO or NMSN.

Employees may request and receive, free of charge, a copy of Plan procedures relating to QMCSOs and NMSNs.

If an Employee is not enrolled in the Plan, and the Employee would otherwise be eligible for coverage, the Plan must enroll child(ren) and the Eligible Employee covered by the QMCSO.

This Plan will also provide benefits to Dependent children placed for adoption on the same basis as natural children even prior to the adoption becoming final. A child will be considered "Placed for Adoption" with a Covered Employee if the Covered Employee has assumed a legal obligation for total or partial support of the child in anticipation of adoption of the child. For this reason, if a child is placed with a Covered Employee for adoption by an adoption agency or other entity, the Covered Employee must provide to the Plan Administrator documentation (e.g., signed court order) that the adoption agency or other entity had legal custody of the child on the date that the child was placed with the Covered Employee for adoption. The Plan Administrator will determine within a reasonable period of time whether a child has been "Placed for Adoption."

The Plan Administrator has final, discretionary authority to determine: (1) whether a medical child support order qualifies as a QMCSO or NMSN; and (2) whether a child has been " Placed for Adoption."

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

An Eligible Employee, properly enrolled in the Plan, will be referred to as a "Covered Employee."

Each Employee's coverage under the Plan shall become effective on the first day of the month following the Date of Hire provided the Employee completes the eligibility requirement of the Plan and written application for coverage is made on or before or within thirty-one (31) days after the date Employee eligibility requirements are met.

DEPENDENT EFFECTIVE DATE

Dependent coverage under the Plan shall become effective on the date Dependent eligibility requirements are met, provided the Employee makes written application for Dependent coverage on or before or within thirty-one (31) days after the date Dependent eligibility requirements are met subject to the enrollment requirements as follows:

1. In order to become covered under the Plan, Eligible Dependents must be identified on an enrollment/change form.
2. If the Employee makes written request for Dependent coverage on or before or within thirty-one (31) days immediately following his/her own effective date, then each Eligible Dependent will become effective on the same date the Employee's coverage is effective.
3. If the Employee makes written request to add a Dependent child to the Plan in accordance with a Qualified Medical Child Support Order (QMCSO), the effective date of coverage for the Dependent child will be the date specified in the QMCSO. Child(ren) covered by QMCSO's may be enrolled in this Plan if the Employee would otherwise be eligible for coverage regardless of whether the Employee is currently enrolled. The Plan must enroll the child(ren) and the Eligible Employee covered by the Notice without any enrollment restrictions (i.e., they will not be considered Late Enrollees).
4. If the Covered Employee makes written request to add a Dependent spouse and/or child who previously was not eligible for the Plan, the effective date of coverage is the date the individual meets the Plan's definition of Dependent.

LATE ENROLLEE

An Employee or Dependent who enrolls in the Plan more than thirty-one (31) days after the date of his/her initial eligibility is considered a Late Enrollee unless he/she qualifies for a Special Enrollment.

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

Effective September 1, 2005, the Plan provides Special Enrollment rights and Special Enrollment Periods for Employees and their Dependents who previously declined to enroll in the Plan and who remain eligible for the Plan.

SPECIAL ENROLLMENT PERIOD FOR LOSS OF ELIGIBILITY FOR OTHER COVERAGE

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose eligibility for that other coverage (except for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be requested within thirty-one (31) days after the date eligibility for other coverage ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Individuals, who previously declined coverage in the Plan because of other coverage, may be eligible to enroll in the Plan during the Special Enrollment Period if eligibility for other coverage is lost as a result of one of the following:

1. Legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. Loss of dependent status;
3. The plan no longer offers any benefits to a class of similarly situated individuals;
4. An individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
5. Moving out of an HMO service area with no other coverage option available;
6. Termination of benefit package option, unless substitute offered;
7. Employer contributions were terminated; or
8. COBRA continuation coverage was exhausted.

Loss of coverage due to an individual's failure to pay premiums or contributions does not qualify for a Special Enrollment Period. Voluntarily dropping coverage does not trigger Special Enrollment rights because there is no loss of eligibility.

Length of Special Enrollment Period for Loss of Eligibility for Other Coverage

A request for a Special Enrollment due to loss of eligibility for other coverage must be made no later than thirty-one (31) days after the exhaustion of COBRA coverage or the termination of other non-COBRA coverage as a result of the loss of eligibility or termination of Employer contributions toward that coverage.

Effective Date of Coverage Following Special Enrollment for Loss of Eligibility for Other Coverage

The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written application for coverage during a Special Enrollment Period will be the day following the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

1. An Employee who previously declined enrollment and who remains eligible for coverage under the Plan has Special Enrollment rights when the Eligible Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption.
2. A new spouse is entitled to Special Enrollment rights when he/she becomes the spouse of a Covered Employee or when a child becomes a Dependent of a Covered Employee through birth, adoption or placement for adoption.
3. A person is entitled to Special Enrollment rights when the person becomes a Dependent of a Covered Employee through marriage, birth, adoption or placement for adoption.
4. An Employee who previously declined enrollment and remains eligible for coverage under the Plan has Special Enrollment rights for himself/herself and the Employee's spouse if a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

Length of Special Enrollment Period for New Dependents

A request for a Special Enrollment due to acquiring New Dependents must be made no later than thirty-one (31) days after the date of marriage, birth, adoption or placement for adoption.

Effective Date of Coverage Following New Dependent Special Enrollment

The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written application for coverage during a New Dependent Special Enrollment Period will be as follows:

1. In the case of marriage: the date of marriage;
2. In the case of a Dependent's birth: the date of birth; or
3. In the case of a Dependent's adoption or placement for adoption: the date of such adoption or placement for adoption

NOTE: Proof of Qualifying Event for Special Enrollment will be required.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE DENTAL BENEFIT PLAN

The Annual Open Enrollment Period for the Plan is the month of August of each year for coverage to become effective September 1, provided written application for coverage is made on or before the end of the Open Enrollment Period or within thirty-one (31) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. Re-enrollment for Covered Employees is not required unless a Covered Employee requests a coverage change or a Plan Option change.

Lyford CISD allows a choice of Plan Options: Dental Plan I or Dental Plan II. An Eligible Employee can elect one (1) Plan Option for him/herself and the same option for his/her eligible Dependents. LaFeria ISD and Rio Hondo ISD have Dental Plan I only.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless the person qualifies for a Special Enrollment or if there is a Status Change.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written application for coverage under the Plan more than thirty-one (31) days after the date of his/her initial eligibility;
2. He/she was not eligible for a Special Enrollment; or
3. He/she failed to enroll by the end of a Special Enrollment Period.

Effective Date of Coverage for Employee Late Enrollees

The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written application for Dependent coverage after the thirty-one (31) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;
2. The Covered Employee makes written request to add a Dependent after the thirty-one (31) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or
3. An Eligible Employee (not currently enrolled in the Plan) makes written request to add a new Dependent more than thirty-one (31) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees

The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the next Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.

COVERAGE CHANGES

FOR EMPLOYEES PARTICIPATING IN THE SECTION 125 PLAN

Contributions to the Plan are made on a "Salary Reduction" basis under Section 125 of the Internal Revenue Code. This allows premium contributions to be withheld from Employee's paycheck on a "pre-tax" basis before any Federal Income Tax or FICA taxes are calculated.

Once an election is made to participate, this election can only be changed during the next year's Annual Open Enrollment Period for the Plan.

A coverage change is allowed if there is a change in status due to certain events including any of the following:

Status Changes

- Marriage
- Divorce or legal separation (in those states recognizing legal separation)
- Birth or adoption of a child
- Death of spouse or child
- Commencement of spouse's employment
- Termination of spouse's employment
- Significant cost or coverage changes for Employee or spouse
- Change from part-time to full-time employment (or vice-versa)/reduction or increase in hours
- Unpaid leave of absence
- Change in the residence or worksite
- Dependent satisfies or ceases to satisfy the eligibility requirements for coverage
- Qualified Medical Child Support Order (QMCSO)
- Entitlement to or loss of eligibility for Medicare or Medicaid

An election change may be made only if one of these recognized changes in status will result in the gain or loss of eligibility for coverage of the Employee, the Employee's spouse or Dependent.

A written request for addition or deletion of coverage due to a Status Change must be made within thirty-one (31) days of that change or the exception will not apply.

Effective Date of Coverage Following Status Change

Most Status Changes qualify for Special Enrollment, see the Employee and Dependent Special Enrollment Periods section.

If there is a Status Change which does not qualify for a Special Enrollment Period as outlined in the Employee and Dependent Special Enrollment Periods, the effective date of coverage will be the date of the Status Change.

BENEFIT CHANGES

PLAN OPTION CHANGES

Lyford CISD allows a choice of Plan Options. Plan Option changes can only be made once a year during the Annual Open Enrollment Period for the Plan.

TERMINATION OF COVERAGE

EMPLOYEE TERMINATION

Employee's coverage shall automatically terminate at midnight on the earliest of the following dates:

1. The last day of the month in which the Employee's employment terminates or the last day of the period in which the Employee's contract ends;
2. The last day of the month in which the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The date the Employee fails to make any required contribution for coverage;
4. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
5. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
6. The last day of the month following the date the Employee requests termination of coverage;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved leave of absence from work; or
9. The date the Employee dies.

DEPENDENT TERMINATION

The Dependent coverage of an Employee shall automatically terminate at midnight on the earliest of the following dates:

1. The last day of the month in which the Dependent ceases to be an eligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The last day of the month in which the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved leave of absence from work; or
9. The last day of the month following the date the Employee dies.

Coverage may be continued under COBRA, but continuation of coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a Covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of certain Qualifying Events (including loss of coverage due to divorce, legal separation, or a Dependent child ceasing to qualify as a Dependent). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage. See Continuation of Group Health Coverage (COBRA) section for further information.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272 and the Co-op's Section 125 Plan.

COVERAGE DURING LEAVE OF ABSENCE

If, after depletion of sick leave and vacation time, active work ceases due to approved Personal Leave of Absence or approved Family and Medical Leave Act (FMLA) or approved Family, Medical, Disability and/or other temporary leave required by applicable state law, the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work based on the Leaves and Absences Policy of the applicable member school district.

If a condition upon which an approved Leave of Absence would be based starts during a district sponsored holiday period, the approved Leave of Absence will start on the 1st day the district reconvenes school.

If Employee has not returned to Full-time Employment after completion of an approved Family and Medical Leave or approved Family, Medical, Disability and/or other temporary leave required by applicable state law, or if Employee notifies Employer that he/she will not be returning to Full-Time Employment following the Family and Medical Leave or approved Family, Medical, Disability and/or other temporary leave required by applicable state law, coverage under the Plan terminates without the need for further action, subject to COBRA continuation rights. See Continuation of Group Health Coverage (COBRA) section. Failure of Employee to make any required Employee contributions for continued coverage under the Plan during an approved FMLA or other leave of absence will also result in termination of coverage.

Family and Medical Leave is subject to the requirements of the Family and Medical Leave Act (FMLA).

ACTIVE DUTY IN THE ARMED FORCES

If a Covered Employee and/or his/her covered Dependent(s) would lose Plan coverage as a result of the Employee being called for active duty in the armed forces of the United States, such a reduction in hours (or termination of employment) would be a COBRA Qualifying Event. Any coverage mandated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended by the Veterans Benefits Improvement Act of 2004 will run concurrently with federally mandated COBRA coverage. For additional information, see the sections entitled Continuation of Group Health Coverage (COBRA) and Continuation of Coverage under USERRA.

REINSTATEMENT OF COVERAGE

A terminated Employee on COBRA who is rehired and returns to work does not have to satisfy the new Employee Waiting Period or Pre-existing Condition Exclusion provisions of the Plan.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and qualifies for Military Leave under Uniformed Services Employment and Reemployment Rights Act (USERRA) will be reinstated on the date he/she resumes employment with the Co-op provided that such resumption of employment is within the time period specified in USERRA. The Pre-existing Condition Exclusion Limitation will not apply to an Employee who is entitled to and is reinstated immediately after military service under USERRA. (This waiver does not provide coverage for an Illness or Injury caused or aggravated by military service as determined by the Veterans Administration).

The Reinstatement procedures following a USERRA military leave are subject to the requirements of USERRA.

FAMILY AND MEDICAL LEAVE (FMLA)

All Employers employing at least fifty (50) workers within a seventy-five (75) mile radius of the work place must provide eligible Employees with up to twelve (12) weeks of job-protected leave of absence during a twelve (12) month period, as determined by the Employer, generally for any of the following situations:

- The birth or adoption of a child;
- The serious illness of the Employee's spouse, child, or parent; or
- The Employee's own disabling serious illness.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: an Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee Benefits may include:

▪ group life	▪ medical	▪ dental
▪ educational benefits	▪ annual leave	▪ pensions
▪ sick leave	▪ disability	

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. This means that new Waiting Periods and Pre-existing Condition Limitations are not applied. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee Benefits may or may not be applicable to every Co-op member school district's Plan of Benefits. This section is intended as a summary of the Family and Medical Leave Act of 1993 (FMLA) effective August 5, 1993, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Co-op member school district's Leaves and Absences Policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE

(Applies to Dental Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2 percent.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

<u>Qualified Beneficiary</u>	<u>Qualifying Event</u>	<u>Maximum Coverage Period</u>
Covered Employee and/or Covered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction of hours	29 months
Covered Dependent	Loss of coverage due to divorce, legal separation, or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent child losing eligibility as a Dependent child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare See Special Medicare Entitlement Rule section.	36 months

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

*SOCIAL SECURITY DISABILITY

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment, reduction in hours or if a Covered Employee or a covered Dependent becomes disabled at any time during the first sixty (60) days of COBRA continuation coverage, the disabled person may continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, not later than eighteen (18) months after the date of loss of coverage due to termination of employment or reduction in hours, that the individual is disabled and the individual notifies the Plan Administrator of the determination within sixty (60) days after the determination is made.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150 percent of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on Covered Employee's loss of coverage due to termination of employment or reduction of hours and a second Qualifying Event (divorce, legal separation, death or a Dependent child losing eligibility as a Dependent child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2002, the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2004 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2005.

SPECIAL MEDICARE ENTITLEMENT RULE

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.

EMPLOYEE RESPONSIBILITIES

COBRA coverage is not automatic upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a Dependent child losing eligibility as a Dependent child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage is elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of fifty dollars (\$50) or ten percent (10%) of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously discussed upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election, unless the other plan contains any exclusion or limitation with respect to a Pre-existing Condition of the individual;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a child who is born to, or a child who is placed for adoption with the Covered Employee Qualified Beneficiary. If the newborn or adopted child is added to the Covered Employee's COBRA continuation coverage, then unlike a new spouse, the newborn or adopted child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction of hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, when applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

EXPANDED COBRA AND HIPAA BENEFIT PROTECTION TRADE BILL OF 2002

The Trade Bill of 2002 expanded COBRA and HIPAA benefit protections for certain COBRA Qualified Beneficiaries who lose jobs and health benefits as a result of American jobs lost to overseas business or those affected by increased foreign imports.

Eligible COBRA Qualified Beneficiaries: To be eligible for TAA (Trade Adjustment Assistance) Benefits, an Employee must have been laid off or put on a reduced work schedule (hours of work reduced to 80% or less of average weekly hours and wages reduced to 80% or less of average weekly wage) on or after the impact date and before the ending date of certification.

In order for the U.S. Department of Labor to issue a Certification Regarding Eligibility to apply for Worker Adjustment Assistance, the following requirements must be met:

1. that workers have been totally or partially laid off; or
2. that sales or productions have declined; or
3. that increased imports have contributed importantly to worker layoffs.

Once the U.S. Department of Labor issues a Certification Regarding Eligibility, trade affected workers may apply for benefits under the TAA program.

If certification is received, then affected Qualified Beneficiaries are eligible for the expanded COBRA/HIPAA protections as follows:

65% COBRA Premium Tax Credit: While the tax credit is technically available back to January 1, 2002, a TAA Qualified Beneficiary can only claim the tax credit for months beginning 90 days after the enactment of the act on August 6, 2002 (November 6, 2002).

60-Day COBRA Election Period and New 18 Month Period: Since January 1, 2002, many TAA Qualified Beneficiaries have been offered the opportunity to elect continuation coverage, but did not do so because of the cost. In an effort to provide the tax credit to as many Qualified Beneficiaries as possible, Congress added a special 60-day COBRA election period to the Trade Bill.

HIPAA 63-Day Break in Coverage Rule Waived: When there is a break in coverage of more than 63 days between the time the original coverage ended and the time the COBRA continuation coverage would begin, current federal HIPAA rules would leave the Qualified Beneficiary subject to Pre-Existing Condition Exclusion provisions. Under the new Trade Bill provisions, under the above circumstances, the break in coverage would not be considered a break in coverage for purposes of portability.

CONTINUATION OF COVERAGE UNDER USERRA

This section summarizes continuation of coverage under this Plan for employees absent from work due to military service. The Plan intends to provide benefits as a result of military leave of absence as mandated by USERRA, as it may be amended from time to time.

As an Employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

If you choose Continuation of Coverage under USERRA, the Employer is required to offer you coverage identical to that provided under the Plan prior to your military leave. If you take military leave on or after December 10, 2004 and you lose coverage due to that military service, you have the right to elect to extend coverage for you, your spouse and your dependents who are covered by the Plan for up to twenty-four (24) months while you remain on active duty, or during the period that your reemployment rights are protected. During the first thirty (30) days of leave, the cost of the coverage you elect is the same as the rate that you paid as an Employee. After that time, the rate is the same rate that the Plan charges for COBRA continuation coverage. If you or another member of your family covered by the Plan become disabled during the first sixty (60) days of such coverage, and you provide to the Plan a copy of the Social Security Administration determination of disability before the end of the twenty-four (24) months of coverage, the coverage by the Plan for you as well as your spouse and other family members can be extended to twenty-nine (29) months. You will have to pay a higher rate for this additional five (5) months of coverage. In addition, if there is an event that would allow your spouse or dependent to receive thirty-six (36) months of COBRA coverage, as described above under the COBRA Continuation Coverage provisions, then your spouse or dependent will be entitled to elect such coverage if they notify the Plan within sixty (60) days after the event occurs.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type, but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases determined based on the content in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Accidental Injury: See definition of "Injury."

Actively at Work: As applied to an Employee: the Employee will be considered "Actively at Work" on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed "Actively at Work" on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was "Actively at Work" on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Expense: The term "Allowable Expense" means any necessary item of expense, for which the charge is Usual and Customary, or is based on the contracted fee schedule of an alternate care delivery system.

Authorized Representative: Person authorized to act on behalf of Claimant for a benefit claim or appeal of an Adverse Benefit Determination.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: That portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of the Calendar Year Deductible which are to be paid by the Employee.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Certificate of Coverage (COC): A certificate verifying an individual's Creditable Coverage.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit claims.

Claim Determination Period: A Calendar Year, a Plan Year or that portion of a Calendar or Plan Year during which the Covered Person, for whom claim is made, has been covered under this Plan.

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Close Relative: Includes the spouse, mother, father, sister, brother, child, or in-laws of the Covered Person.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage: Coverage under this Plan that satisfies an applicable COBRA continuation provision.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect continuation coverage under COBRA. This sixty (60) day period begins no later than:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect COBRA continuation coverage under this Plan.

COBRA Qualified Beneficiary: Any former Employee or Dependent covered under this Plan on the day before the Qualifying Event, who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person's or Family's Annual Out-of-Pocket Maximum.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Charges: The Usual and Customary (U&C) fees incurred by the Covered Person for dental services which are: 1. provided or rendered by a Dentist; 2. listed in the Schedule of Dental and Orthodontic Benefits; and 3. not listed as an exclusion in General Dental Plan Limitations and Exclusions.

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

Date of Hire: The Employee's first day of full-time employment with the Employer.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage. "Deductible" also means that dollar amount of the expense of a particular procedure or Covered Expense for which it is indicated in the Schedule of Benefits that a special Deductible will apply. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Dependent: The term "Dependent" means:

A. The Covered Employee's legal spouse. Such spouse must have met all requirements of a valid marriage contract in accordance with the laws of the state of such parties. A common-law marriage recognized by the state in which the Covered Employee resides is considered a legal marriage for this Plan. **NOTE:** Proof of legal status may be required by the Plan Administrator.

B. The Covered Employee's child who meets all of the following conditions:

1. Is unmarried;

2. Is either a:
 - a. natural child; or
 - b. grandchild; or
 - c. step-child; or
 - d. child who has been placed under the legal guardianship of the Covered Employee; or
 - e. child under the age of eighteen (18) who has been legally adopted or placed for adoption with the Covered Employee; and
3. Is in the custody of, residing with and financially dependent for primary support upon the Covered Employee. This condition is waived if the child is a natural child or a legally adopted child or if the Employee is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) or divorce decree for a child not in his/her custody or not wholly dependent upon him; and
4. Is carried as an exemption on the Covered Employee's federal income tax return. This condition is waived if the child is a natural child or a legally adopted child or if the Employee is required to provide coverage due to a Qualified Medical Child Support Order (QMCSO) or divorce decree for a child not carried as an exemption on the Covered Employee's federal income tax return; and
5. Is less than **twenty-five (25) years of age**, unmarried and is primarily dependent upon the Covered Employee for support.

The age requirement above is also waived for any unmarried mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Covered Employee for support and maintenance. Proof of incapacity must be furnished to the Plan Administrator at the time of enrollment or within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement. In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

NOTE: Proof of Dependent eligibility may be required.

Electronic Protected Health Information (ePHI): The term "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligible Dependent: An Employee's Dependent who is eligible to enroll for coverage in the Plan while the Employee is covered under the Plan.

Eligible Employee: An Employee who has satisfied the applicable Waiting Period and who is employed by the Employer on a permanent full-time basis of at least an average of twenty (20) hours per week, not to include seasonal or temporary employees.

Employee: Any person who is regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Employer: The Co-op and any school districts adopting the Plan with the consent of the Co-op.

Enrollment Date: The Enrollment Date in the Plan for an Eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan. The term "Enrollment Date" is used to determine the Pre-existing Condition look-back and exclusion periods for the Plan.

Experimental/Investigational: Any treatments, procedures, drugs, medicines or related expenses for which one or more of the following is true:

1. The device, drug, medicine or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and full approval has not been given at the time the device, drug, medicine or biological product is furnished;

2. Reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing Phase I, II or III clinical trial or under scientific study to determine its maximum tolerated doses, toxicity, safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis;
3. The Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety; or
4. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means published reports and articles in authoritative and scientific literature; written protocol(s) used by treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or another facility studying substantially the same treatment, procedure, device, drug or medicine.

Medical treatment which is not considered standard treatment (i.e., not of proven benefit for a particular diagnosis) by the majority of the medical community or by Medicare/Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational.

Family: A Covered Employee and his/her eligible Dependents.

Family and Medical Leave: A leave of absence pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended.

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

Full-Time Employment: A basis whereby an Employee is employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance set standards for Pre-existing Condition exclusion periods and changed health status eligibility provisions for employee health plans.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Illness: A bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Incurred Expenses: Those services and supplies rendered to a Covered Person. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty-one (31) days after the date of his/her eligibility and who was not eligible for a Special Enrollment Period or who failed to enroll by the end of a Special Enrollment Period. Late Enrollees can only enroll once a year during the Annual Open Enrollment Period for the Plan.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modification or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Amounts: Any Lifetime Maximum amounts or Calendar Year Maximum amounts or any Maximum amounts otherwise specified are applicable to the total expenses paid during all Plan Years whether or not the Covered Person has been continuously covered under this Plan and any prior Plan Years under this Employer's Plan.

Medicare Benefits: All benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as amended, from time to time.

No-Fault Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the accident.

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) effective August 10, 1993.

Part-time Employee: Any Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility Section of this Plan Document.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Physically or Mentally Handicapped: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Placement for Adoption: A child under the age of eighteen (18) placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: South Texas Health Cooperative, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services.

Plan Amendment: 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: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: South Texas Health Cooperative.

Plan Year: September 1 through August 31 of the next Calendar Year. The Plan Year is the year on which Plan records are kept.

Practitioner: A Physician or person acting within the scope of applicable state licensure/certification requirements includes the following:

1. Doctor of Dental Medicine (D.M.D.)
2. Doctor of Dental Surgery (D.D.S.)

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a medical child support order that satisfies the following requirements to be a Qualified Medical Child Support Order:

1. The name and last known mailing address of the Covered Employee.
2. The name and address of each alternate recipient. "Alternate recipient" means any child of a Covered Employee who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Covered Employee.
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined.
4. The period for which coverage must be provided.
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

Security Incidents: The term "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Significant Break in Coverage: A period of sixty-three (63) consecutive days or more during which the Employee or Dependent did not have any Creditable Coverage. Waiting Periods are not considered in determining Significant Breaks in Coverage.

Special Enrollee: An Eligible Employee and his/her eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty-one (31) days in which an Eligible Employee or Dependent who previously declined enrollment in the Plan by signing a waiver of coverage, can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of eligibility for other coverage (except for cause or non-payment of premium); or
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint Syndrome (TMJ): Also known as myofascial pain-dysfunction syndrome, is a disorder that affects the two joints at either side of the jaw (the temporomandibular joints).

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of an Employee, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. In the case of a Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A federal law which applies to persons who have been absent from work because of "service in the uniformed services." "Uniformed services" consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or emergency. "Service" in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work for an examination to determine a person's fitness for any of the designated types of duty.

Usual and Customary (U&C):

1. The Usual fee - the fee most frequently charged or accepted for covered medical care or supplies by a Physician or Hospital; and
2. The Customary fee - the fee charged or accepted for covered medical care or supplies by those of similar professional standing in the same geographical area; "area" means a region large enough to determine a cross section of providers of medical care or supplies.