LTX, INCORPORATED

Summary Plan Description

P.O. BOX 27267
MINNEAPOLIS, MN 55427-0267

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GENERAL INFORMATION

Name of Plan: LTX, Incorporated
Employee Dental Benefit Plan

Type of Plan: Self-funded welfare plan providing dental coverage.

Plan Number: 506

Plan Administrator: LTX, Incorporated
1515 Industrial Drive N.W.
Rochester, MN 55901
(507) 282-6715

Group Number: 10717

Participating Employers & Employer Tax ID Numbers:

LTX, Incorporated:	41-0908878
Lawrence Transportation Company:	41-1884879
Wilson Refrigerated Express, Inc.:	41-1337548
Lawrence Leasing, Inc.:	41-1709172
Freight Plus, Inc.:	41-2008992
Lawrence Risk Management Services, Inc.:	20-1679618

Plan Effective Date: January 1, 2001
Plan Restated Date: November 1, 2007

Plan Renewal Date: January 1

Plan Year Ends: December 31

Agent for Legal Service:
(Process may be serviced upon the Plan Administrator) LTX, Incorporated
1515 Industrial Drive N.W.
Rochester, MN 55901
(507) 282-6715

Contract Administrator: Meritain Health[sm]
P.O. Box 27267
Minneapolis, MN 55427-0267
(952) 546-0062
(800) 925-2272

Named Fiduciary: LTX, Incorporated
1515 Industrial Drive N.W.
Rochester, MN 55901
(507) 282-6715

Contributions: The cost of coverage provided by the Employer will be funded in part by Employer contributions and in part by employee contributions. The Employer will determine and periodically communicate the employee's share of the cost of coverage, and it may change that determination at any time.

Funding: Coverage for employees and their eligible dependents are paid in part by the Employer out of its general assets and in part by employee contributions.

Effective Date of Coverage:	See **Eligibility, Enrollment & Effective Date of Coverage** section.
Termination Date of Coverage:	See **Termination of Benefits** section.
Important Disclaimer:	Benefits hereunder are provided pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such governing plan document, the terms of the governing plan document will control, rather than this document, unless otherwise required by law.

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SCHEDULE OF DENTAL BENEFITS	
PRE-DETERMINATION LIMIT	$400
CALENDAR YEAR DEDUCTIBLE Individual Family	 $50 $150
DENTAL BENEFITS	
Class "A" Expenses (Preventive Services)	100%; Deductible waived
Class "B" Expenses (Basic Services)	80% after the Deductible
Class "C" Expenses (Major Services)	50% after the Deductible
CALENDAR YEAR MAXIMUM BENEFIT (Classes "A", "B" and "C" Expenses Combined per Person)	$1,000*
* During the first year of coverage, benefits will be limited to $500 per person.	
Orthodontic Treatment (For dependents under age 18) Lifetime Maximum Benefit	50% after Deductible $1,000

ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE

A - ELIGIBLE EMPLOYEES

A full-time employee of the Employer who regularly works **thirty-two (32)** or more hours per week will be eligible to enroll for coverage under this Plan. An employee must have a legal right to work in the United States in order to be eligible for coverage under this Plan. Other employees such as part-time, temporary or seasonal will not be eligible to enroll for coverage under this Plan.

An employee's participation in the Plan is subject to a waiting period of ninety (90) days of continuous full-time employment, from the date such full-time employment begins.

An employee's Eligibility Date is the first of the month following completion of the waiting period.

B - ELIGIBLE DEPENDENTS

An Eligible Dependent will be a Covered Employee's legally married spouse and each unmarried child who is not yet age nineteen (19), provided such child is dependent on the employee for support and maintenance. The term “married” means only a legal union between one man and one woman as husband and wife, and the term “spouse” refers only to a person of the opposite sex who is a husband or wife.

The term "child", as used herein, shall be defined as: (a) a natural born child; (b) a foster child; (c) a stepchild; (d) an adopted child (from the date of placement with the employee for the purpose of legal adoption); (e) a child for whom the employee is the Legal Guardian, until the date the child no longer qualifies as an Eligible Dependent as defined under this Plan; (f) unmarried grandchildren to age nineteen (19) who live with the employee continuously from birth and are financially dependent upon the employee for at least 50% of their support; or (g) a child for whom the employee is required to provide dental coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Contract Administrator at no cost.

The Plan Administrator shall have the right to require documentation necessary, in its sole discretion, to establish an individual’s status as an Eligible Dependent.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

Full-Time Student: The term “Full-Time Student,” as used herein, shall be defined as an unmarried dependent child who is enrolled in and regularly attending an educational institution such as high school, an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, business college, mortuary school, cosmetology school, community or junior college, or other similar accredited educational institution that offers a full-time curriculum. The institution must be accredited in order to qualify the dependent for Full-Time Student status.

If an unmarried child is or becomes a Full-Time Student while between the ages of nineteen (19) and twenty-three (23) and is dependent upon the employee for support and maintenance, then such child will be considered an Eligible Dependent until the date the child attains age twenty-three (23). Coverage for a Full-Time Student will be effective as follows:

1. A dependent child covered by this Plan who graduates from high school will remain covered provided the child enrolls and begins attending classes full-time in an accredited post-secondary school, college, or university within four (4) months of the child’s high school graduation date; or

2. A dependent child who is not covered by this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage. In this instance, the date the child begins attending full-time classes will be considered the date the employee acquires an Eligible Dependent for plan enrollment purposes. The Plan may require a completed application for the dependent’s coverage within a specified time frame (see section C - Plan Enrollment); and

3. A Full-Time Student will remain covered during any regular scheduled break in the educational institution's full-time curriculum (such as spring or summer break), as long as the dependent was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break.

If a dependent child ceases to maintain Full-Time Student status, the dependent child's coverage will cease on the day following the dependent's last day in attendance as a Full-Time Student. For purposes of offering Continuation of Benefits (COBRA) to such dependent child, the sixty (60) day period during which the Plan must be notified of the dependent's ineligibility will begin the earlier of:

1. The start of classes in the next quarter/semester designated by the last school attended; or

2. In the case of withdrawal from enrollment or graduation, the day after withdrawal or graduation.

Mentally or Physically Handicapped Child: If an unmarried dependent child, upon reaching age nineteen (19), is incapacitated, unable to be self-supporting, and resides with the employee, then such child will continue to be an Eligible Dependent.

C - PLAN ENROLLMENT (TIMELY, SPECIAL AND LATE ENROLLMENT)

Timely Enrollment: An Eligible Employee who elects to participate in the Plan must complete, sign, and return the provided "enrollment form" to the Employer within thirty-one (31) days of the Eligibility Date. Failure to enroll within this time limit will be deemed waiver of participation and the employee or dependents will be considered Late Enrollees or Special Enrollees.

An Eligible Dependent is able to participate in the Plan when the Covered Employee completes, signs and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty-one (31) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any Eligible Dependents at that time; or

2. The date the employee acquires an Eligible Dependent.

Children covered by Qualified Medical Child Support Orders (QMCSO) 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 employee covered by the notice without any enrollment restrictions (i.e. they will not be considered Late Enrollees).

If dependent coverage is already in force, the employee does not have to enroll additional dependent children acquired after dependent coverage is in force.

If dependent coverage is not already in force, newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption.

Special Enrollment: If an employee is declining enrollment for single or family coverage because of other dental coverage under a Qualified Health Plan, the employee may in the future be able to enroll for single or family coverage, provided the request for enrollment is received within thirty-one (31) days after coverage under the Qualified Health Plan terminates due to one or more of the following:

1. Loss of eligibility, which includes, but is not limited to:

    (a) Legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment;
    (b) Coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual);
    (c) Coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(d) When a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit);
(e) When a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.

2. Termination of employer contributions toward the cost of coverage; or

3. COBRA continuation coverage is exhausted.

If an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll for coverage, provided the employee requests enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption of a new dependent child.

A written waiver of coverage stating the existence of coverage under another Qualified Health Plan must have been completed by the employee in order for the employee to be considered a Special Enrollee at a later date.

Late Enrollment/Open Enrollment: There will be an annual open enrollment period during the month of December, at which time a Late Enrollee may elect single or family coverage under the Plan to be effective on January 1st. The waiting period will be waived. However, during the first twelve (12) months coverage will be limited to Class "A" Expenses only.

D - RE-HIRE

If an employee who was previously covered by this Plan is re-hired within six (6) months after termination of employment, coverage will become effective on the date of re-employment and the waiting period will be waived.

If an employee who was previously covered by this Plan is re-hired more than six (6) months after termination of employment, the employee will be considered a new employee and will be subject to all provisions of this Plan.

E - ACQUISITIONS

All Eligible Employees (including any Eligible Dependents) acquired through a contract with LTX, Incorporated are hereby eligible for coverage under this Plan effective on the date of the contract. The waiting period and the Late Enrollment Restriction will be waived provided they were covered under the Employer-sponsored plan which is immediately replaced by this Plan. All other provisions of this Plan will apply.

Any Deductible amounts satisfied with the Employer-sponsored plan immediately replaced by this Plan will be credited toward satisfaction of this Plan's Deductible requirements.

F - RETURN TO WORK – USERRA

Employees who are covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) will be eligible for coverage on the date they return to work, provided the employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. Eligibility waiting periods will be imposed only to the extent they were applicable prior to the period of uniformed services. See the **Termination of Benefits** section for more information regarding USERRA.

G - EFFECTIVE DATE OF COVERAGE

Timely Enrollees:

1. **Employees**: The employee's Eligibility Date if the employee enrolls within thirty-one (31) days thereafter.

2. **Dependents**:

(a) The employee's effective date of coverage; or
(b) In the case of a newly eligible or returning Full-Time Student, the date the dependent child begins attending full-time classes.

Special Enrollees:

1. The day following the date the employee or dependent's coverage terminated due to loss of eligibility under a Qualified Health Plan, provided enrollment is received within thirty-one (31) days of losing coverage.

2. The day following the date the employee or dependent's coverage terminated due to termination of employer contributions toward the cost of coverage, provided enrollment is received within thirty-one (31) days of losing coverage.

3. The date of marriage, provided the employee enrolls for single or family coverage within thirty-one (31) days of the marriage.

4. The date of birth or adoption (or placement for adoption) of a new dependent, provided the employee enrolls for single or family coverage within thirty-one (31) days of the birth, adoption or placement for adoption.

5. The day following the date in which COBRA coverage is exhausted if the employee or dependent had elected COBRA coverage under a Qualified Health Plan, provided enrollment is received within thirty-one (31) days of exhausting benefits.

Late Enrollees:

1. January 1st following the Open Enrollment period for a Late Enrollee.

ELIGIBLE DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they:

1. Are Usual and Customary;

2. Constitute necessary treatment;

3. Are incurred while covered under this Plan; and

4. Not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

DATE EXPENSES ARE INCURRED

An expense is incurred when the service is performed, except that it is deemed to be incurred:

1. When the impression is taken in the case of dentures, or fixed bridgework;

2. When preparation of the tooth is begun in the case of crown work;

3. When the pulp chamber is opened in the case of root canal therapy.

PRE-DETERMINATION OF BENEFITS

When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the **Schedule of Benefits**, the Dentist's treatment plan should be sent to the Contract Administrator before the first date of treatment. Based on the treatment plan, the Contract Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination. The treatment plan should:

1. Show the Dentist's proposed course of treatment;

2. Show the total charge for the treatment;

3. Include x-rays, study models and any other data requested by the Contract Administrator;

4. Show how long the treatment will take; and

5. Show the classification of malocclusion (if the treatment plan is for Orthodontic Treatment).

Pre-determination is not necessary when eligible dental expenses are incurred for emergency dental care or accidental dental Injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

1. The work being done as proposed and while the Covered Person is covered under this Plan; and

2. The Deductible and payment limit provisions and all of the other terms of this Plan.

ALTERNATIVE TREATMENT

In all cases in which there are optional treatments available which produce a professionally satisfactory result, only the least costly alternative will be considered eligible under this Plan.

ELIGIBLE DENTAL EXPENSES

The following is a complete list of dental procedures covered under this Dental Expense Benefit, any procedure not listed is excluded.

CLASS "A" EXPENSES (Preventive Services):

1. Routine oral examinations are limited to twice per twelve (12) month period.

2. X-rays as follows:

   (a) Full mouth and panorex x-rays are limited to once in any three (3) year period, unless special need is shown;
   (b) Bitewing x-rays are limited to twice per twelve (12) month period; and
   (c) Periapical x-rays.

3. Prophylaxis (cleaning, scaling, and polishing) is limited to twice per twelve (12) month period.

4. Topical application of fluoride for dependent children under age fourteen (14), is limited to one treatment in any twelve (12) month period.

5. Space maintainers for dependent children under age sixteen (16).

CLASS "B" EXPENSES (Basic Services):

1. General anesthesia in connection with covered oral surgery only.

2. Emergency palliative treatment.

3. Endodontic treatment, including root canal therapy.

4. Periodontic treatment, including periodontic prophylaxis.

5. Fillings: amalgam, acrylic and synthetic.

6. Oral surgery, including extractions.

7. Stainless steel crowns.

8. Antibiotic drug injections.

CLASS "C" EXPENSES (Major Services):

1. Crowns, gold fillings, inlays, and onlays.

2. Initial installation of, or addition to, full or partial dentures or fixed bridgework. (Dentures and bridgework will be considered to be initially installed only if the dentures or bridgework do not replace existing dentures or bridgework.) Such denture or bridgework includes the replacement of any extracted teeth and must be completed within twelve (12) months of when work is started.

3. Replacement or alteration of full or partial denture or fixed bridgework, if more than five (5) years after the last installation. Such expenses must have occurred on or after the effective date of coverage under the Plan, and must be completed within twelve (12) months.

ORTHODONTIA: (For dependents under age 18)

Charges are eligible only to the extent that they are made in connection with an orthodontic procedure, including:

1. Cephalometric x-rays;

2. Diagnostic casts for orthodontic purposes;

3. Surgical exposure of an impacted tooth for orthodontic purposes;

4. Orthodontic appliances for tooth guidance;

5. Fixed or removable appliances to correct harmful habits.

Eligible expenses include those for preliminary study and treatment plan. Also covered under this benefit is extractions for the purposes of Orthodontic Treatment. The first month of active treatment includes all active and retention appliances. Payments will be made in equal installments for the duration of covered treatment, until no longer covered, or until the maximum benefit has been paid, whichever occurs first.

DENTAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **ALTERNATIVE TREATMENT**: Expenses where there are alternate courses of treatment available carrying different fees, the Plan will provide benefits only for the treatment carrying the lesser fee.

2. **AMERICAN DENTAL ASSOCIATION**: Expenses which do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

3. **CLOSE RELATIVE**: Expenses for services, care, or supplies provided by a Close Relative will not be considered eligible.

4. **COSMETIC:** Expenses for services or supplies partially or wholly Cosmetic in nature will not be considered eligible.

5. **DEPARTMENT MAINTAINED BY AN EMPLOYER**: Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.

6. **DUPLICATE DEVICES**: Expenses for duplicate prosthetic devices or appliances; expenses for a lost or stolen dental appliance will not be considered eligible.

7. **GOVERNMENTAL AGENCY**: Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

8. **HOSPITAL EXPENSES**: Expenses for hospital expenses will not be considered eligible.

9. **IMPLANTS:** Expenses for tooth implants will not be considered eligible.

10. **INSTALLATION OR REPLACEMENT**: Expenses for installation, replacement or alteration of, or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in **Eligible Dental Expenses.**

11. **MISSED APPOINTMENTS**: Expenses for completion of claim forms, missed appointments, or telephone consultations will not be considered eligible.

12. **MISSING TEETH**: Expenses for initial placement of a complete or partial denture or fixed bridgework if it involves the replacement of one or more natural teeth missing or lost prior to the date the individual became covered will not be considered eligible. This exclusion will not apply if the denture or bridgework includes replacement of natural teeth extracted while covered.

    Expenses for any dental services or supplies for treatment of teeth missing prior to the effective date of coverage (including congenitally missing teeth) will not be considered eligible.

13. **NOT LISTED AS ELIGIBLE:** Expenses for procedures or restorations, other than those listed in the **Eligible Dental Expenses** section, will not be considered eligible.

14. **NOT PERFORMED BY A DENTIST**: Expenses for treatment by other than a Dentist or physician will not be considered eligible, except charges for treatment performed under the supervision and direction of a Dentist or physician, by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations.

15. **NOT PRESCRIBED BY A DENTIST**: Expenses for services not prescribed as necessary by a physician or Dentist will not be considered eligible.

16. **OPERATED BY THE GOVERNMENT**: Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

17. **ORAL HYGIENE**: Expenses for oral hygiene, dietary or plaque control programs, or other educational programs will not be considered eligible.

18. **PRIOR TO EFFECTIVE DATE:** Expenses which are incurred prior to the effective date of coverage, or after the termination date of coverage will not be considered eligible.

19. **SEALANTS:** Expenses incurred for sealants will not be considered eligible.

20. **TAKE HOME ITEMS:** Expenses for mouth guards or take home items will not be considered eligible.

21. **TEMPORARY PROSTHESIS:** Expenses for a temporary full prosthesis or for adjustment or relining of a prosthesis within six (6) months after the prosthesis is initially furnished will not be considered eligible.

22. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ)**: Expenses incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible.

23. **USUAL AND CUSTOMARY CHARGES**: Expenses in excess of the Usual and Customary Charge will not be considered eligible.

24. **WAGE OR PROFIT:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment).

25. **WAR:** Expenses for the treatment of Illness or Injury resulting from war or any act of war, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.

26. **WORKER'S COMPENSATION**: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

    Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

INTEGRATION WITH MEDICAL BENEFITS

In the event benefits are available for the same expenses under both the medical and dental plans sponsored by the Employer, such charges will first be considered for payment as a medical expense. The charges will be considered under the Dental Expense Benefit only if the amount normally paid under the Dental Expense Benefit exceeds the amount paid under the medical expenses, and only up to the excess amount.

DEFINITIONS

The following defined terms are capitalized and used throughout the document:

ACCIDENT/ACCIDENTAL: An unforeseen or unexplained sudden occurrence by chance without intent or violation.

ADVERSE BENEFIT DETERMINATION: Means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

AUTHORIZED REPRESENTATIVE: A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's dental condition is also permitted to act as the Claimant's Authorized Representative.

CALENDAR YEAR: January 1 through December 31 each year.

CLAIM FOR BENEFITS: A request for a plan benefit or benefits made by a claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A claim for benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

CLAIMANT: A person requesting benefits under the Plan. A Claimant may or may not be a Covered Person under the Plan.

CLOSE RELATIVE: A Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

CO-INSURANCE: The percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Co-insurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the **Schedule of Benefits**.

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

CONCURRENT CARE: Ongoing care or course of treatment.

CONTRACT ADMINISTRATOR: The organization providing services to the Employer in connection with the operation of this Plan and performing such other functions, including processing of claims, as may be delegated to it.

COSMETIC: Any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

COVERED EMPLOYEE: An Eligible Employee whose coverage has become effective and has not terminated.

COVERED PERSON: An Eligible Employee or Eligible Dependent whose coverage has become effective and has not terminated.

DEDUCTIBLE: The total amount of eligible expenses, as shown in the **Schedule of Benefits**, which must be incurred by a Covered Person during any Calendar Year before covered expenses are payable under the Plan. The Family Deductible maximum, as shown in the **Schedule of Benefits**, is the maximum amount which must be incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

DENTIST: An individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A physician will be considered a Dentist when performing any covered dental services allowed within such license.

ELIGIBILITY DATE: The first date of coverage after the Eligible Employee has satisfied any applicable waiting period. See **Eligibility & Enrollment** section.

EMPLOYER: LTX, Incorporated, or any successor thereto.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

HEALTH CARE PROFESSIONAL: A Physician or other Health Care Professional licensed, accredited, or certified to perform specified dental services consistent with State law.

INJURY: A bodily Injury which results independently of Illness and is caused by accidental means. All bodily Injuries sustained in any one accident and all related conditions and recurrent symptoms will be considered one Injury.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who does not elect coverage under this Plan within thirty-one (31) days of their Eligibility Date and who is not otherwise considered a Special Enrollee. An employee not enrolled or not eligible for coverage under the Employer's previous Employer-sponsored plan will be considered a Late Enrollee.

LEGAL GUARDIAN: A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

LIFETIME MAXIMUM: The maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan provides for a Lifetime Maximum Benefit for specific types of dental treatment as shown in the **Schedule of Benefits**.

ORTHODONTIC TREATMENT: The corrective movement of teeth to treat a handicapping malocclusion of the mouth.

PLAN: The LTX, Incorporated Employee Dental Benefit Plan, and any amendments attached thereto.

PLAN ADMINISTRATOR: The Employer, which is sponsoring this Plan for its employees. The Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

POST-SERVICE CLAIM: Post-Service Claims are all claims that are not Pre-Service Claims.

PRE-SERVICE CLAIM: Pre-Service Claims is any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

QUALIFIED HEALTH PLAN: The following will be considered Qualified Health Plans: (1) a group health or dental plan; (2) health or dental insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) federal employees health or dental insurance coverage; (9) public health or dental plan; and (10) Peace Corps plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO): A judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an employee pursuant to a state domestic relations law.

SPECIAL ENROLLEE: See the **Eligibility, Enrollment & Effective Date of Coverage** section.

URGENT CARE CLAIM: Any Pre-Service Claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's dental condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

USUAL AND CUSTOMARY CHARGE: Charges made for dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any dental complications or unusual circumstances which require additional time, skill or experience.

TERMINATION OF BENEFITS

An employee's or dependent's coverage shall terminate at the earliest time indicated below:

1. In the event the employee fails to make any required contributions when due, benefits shall automatically terminate at the end of the period for which the contribution was made.

2. Upon termination of employment or retirement, benefits will cease on the day the employee terminated. Cessation of active work by an employee shall be deemed termination of employment, except as follows:

   (a) In the event an employee is absent on account of Illness or Injury, employment shall be deemed to continue for the purpose of benefits hereunder until the earlier of: (i) the date contributions received from the Employer for such employee's benefits are discontinued; or (ii) a period of six (6) months; or

   (b) The benefits of an employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed six (6) months.

3. The end of the month the employee ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

4. The date the dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

5. When maximum benefits of this Plan have been exhausted.

6. The date the dependent becomes an Eligible Employee.

7. When the employee or dependent enters the military service on a full-time active duty basis, other than scheduled drills or other training not exceeding one month in any Calendar Year.

8. The date the Plan is terminated.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

An eligible employee that qualifies for FMLA is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA. The employee must have worked for the Employer for at least twelve (12) months, and have worked at least 1,250 hours during the twelve (12) months preceding the start of the leave.

An employee may choose not to retain health coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. Coverage will be reinstated without any additional qualification requirements imposed by the Plan. (The Plan's provisions with respect to Deductibles and Co-insurance amounts will apply on the same basis as they did prior to the FMLA leave.)

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If an individual was covered under this Plan immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage may continue for up to twenty-four (24) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution rate will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the individual returns to active employment with the Employer if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the VA to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the Pre-Existing Condition Limitation will be credited as if you had been continuously covered under this Plan from the original effective date, unless the waiting period would have applied to the employee if the employee had remained continuously employed during the period of military leave. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service, as determined by the VA. For complete information regarding the rights under USERRA contact the Employer.)

CONTINUATION OF BENEFITS (COBRA)

COBRA continuation coverage is temporary continuation of Plan coverage that can become available to individuals who are covered under the Plan when a "Qualifying Event" occurs which results in a loss of coverage under the Plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is an individual who is covered under the Plan the day before a Qualifying Event takes place which results in a loss of coverage under the Plan. A Qualified Beneficiary can be the Covered Employee, the covered spouse of the employee, or the covered dependent child(ren) of the employee. Any child born to or placed for adoption with the covered employee during a period of continuation coverage is also considered a Qualified Beneficiary.

If COBRA continuation coverage is elected, coverage will continue as though the Qualifying Event had not occurred. Any Deductible or Co-insurance amounts satisfied, or amounts credited toward any maximum benefits of this Plan, will be retained. Similarly, no new or additional waiting periods requirements will apply.

If any changes are made to the coverage for employees actively-at-work, the coverage provided to individuals under this continuation provision will be similarly changed.

COBRA may not be denied to an individual who had coverage under another group health or dental plan or Medicare prior to a Qualifying Event.

Specific Qualifying Events and the corresponding time period for which continuation coverage is available are listed below. In some instances, Qualified Beneficiaries may be covered under multiple Qualifying Events (see "Extension of Continuation Coverage" below).

QUALIFYING EVENTS

An **eighteen (18) month** continuation is available to employees and/or dependents in the event of any one or both of the following Qualifying Events:

1. An employee's termination of employment for any reason except gross misconduct;
2. An employee's loss of eligibility to participate due to reduced work hours.

In the event that both Qualifying Events happen, the total length of the continuation will not exceed eighteen (18) months.

A **thirty-six (36) month** continuation shall be available to a covered dependent spouse and/or child of an employee in the event of any one of the following Qualifying Events:

1. An employee's death;
2. Divorce or legal separation from the employee;
3. A child ceasing to meet the eligibility requirements described in the **Eligibility & Enrollment** section;
4. A dependent's loss of eligibility to participate in this Plan due to the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), either as the result of disability or choosing Medicare in the place of this plan at age sixty-five (65).

Notification of some Qualifying Events is required. In the case of divorce or legal separation from the employee, or a child ceasing to meet the eligibility requirements, the employee or Qualified Beneficiary must send written notice of the event to the Plan Administrator within sixty (60) days after the later of: (a) the date of the Qualifying Event; (b) the date on which coverage would have been lost as a result of the Qualifying Event; or (c) the date on which the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. This written notice must include supporting legal documentation when applicable (e.g. divorce decree or legal separation agreement). Failure to notify the Plan Administrator as described will cause any Qualified Beneficiary to lose eligibility for COBRA continuation coverage.

If a Qualified Beneficiary has a new dependent eligible for coverage as the result of a marriage or birth, adoption, or placement for adoption of a child, the Qualified Beneficiary must notify the Plan Administrator as described under the **Eligibility & Enrollment** section.

EXTENSION OF CONTINUATION COVERAGE

In certain circumstances, a Qualified Beneficiary may be able to continue coverage beyond the initial eighteen (18) month continuation period.

Due to Disability: An eleven (11) month extension of the eighteen (18) month continuation period (resulting in a total of 29 months of continuation coverage) may be available to all covered family members in the event a Qualified Beneficiary is determined to be disabled by the Social Security Administration. In order to be eligible for this extension, the following requirements must all be satisfied:

1. The initial Qualifying Event must have been either termination of employment or reduction in hours; and

2. The Qualified Beneficiary must be declared disabled by the Social Security Administration on or before the date of the Qualified Beneficiary's initial Qualifying Event, or during the first sixty (60) days of COBRA continuation coverage; and

3. The Qualified Beneficiary must send written notice of a disability determination to the Plan Administrator before the end of the original eighteen (18) months of COBRA continuation coverage and within sixty (60) days of the later of: (a) the date of the disability determination; (b) the date of the initial Qualifying Event; (c) the date coverage would have been lost as a result of the Qualifying Event; or (d) the date on which the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. A copy of the Social Security Administration's determination letter must be included in this written notice.

Failure to meet any of the above requirements will cause the Qualified Beneficiary to lose eligibility for the eleven (11) month extension.

If the Qualified Beneficiary is later determined by the Social Security Administration to no longer be disabled, the Qualified Beneficiary must notify the Plan Administrator in writing of that fact within thirty (30) days of the Social Security Administration's determination.

Multiple Qualifying Events: An eighteen (18) month extension of the initial eighteen (18) month continuation period (resulting in a total of 36 months of continuation coverage) may be available to a Qualified Beneficiary of a former employee who experiences a second Qualifying Event during the first eighteen (18) months of continuation coverage. This extension is not available to the former employee. A second Qualifying Event must be one of the events listed under the **thirty-six (36) month continuation** section and must occur during the initial eighteen (18) month continuation period.

In order to be eligible for this extension, the following requirements must all be satisfied:

1. The initial Qualifying Event must have been either the former employee's termination of employment or reduction in hours; and

2. The event would have to have caused the Qualified Beneficiary to lose coverage under the Plan had the first Qualifying Event not occurred; and

3. The Qualified Beneficiary must send written notice to the Plan Administrator within sixty (60) days of the later of: (a) the date of the second Qualifying Event; (b) the date coverage would have been lost as a result of the Qualifying Event; or (c) the date the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. This written notice must contain supporting legal documentation when applicable (e.g. death certificate, divorce decree, or legal separation agreement).

Failure to notify the Plan Administrator as described will cause the Qualified Beneficiary to lose eligibility for extended COBRA continuation coverage.

In no event will coverage be continued for more than thirty-six (36) months.

NOTICE OF CONTINUATION

At the time coverage commences under the Plan, or as permitted by applicable law, the Plan Administrator will provide written notice to each Covered Employee and spouse (if any) of the right to continuation coverage.

When a Qualifying Event occurs, COBRA continuation coverage will be offered to each affected Qualified Beneficiary, provided any applicable notification requirements have been met. The cost of the continuation coverage will be included with the election form. A Qualified Beneficiary eligible to elect continuation coverage shall have the right to continue the level of coverage in effect on the day before the Qualifying Event.

The decision to elect COBRA continuation coverage is the responsibility of the Qualified Beneficiary. However, failure to continue group dental plan coverage may affect the Qualified Beneficiary's future rights under federal law, including the portability of dental coverage and special enrollment rights as provided by the Health Insurance Portability and Accountability Act (HIPAA), and the guaranteed right to purchase an individual dental insurance policy. For more information on a Covered Person's rights under ERISA, including COBRA and HIPAA, the Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To elect COBRA continuation coverage, the Qualified Beneficiary must complete the election form and return it to the COBRA administrator by mail or fax within sixty (60) days of the date of the notice, or sixty (60) days of the date coverage ends as a result of the Qualifying Event, whichever is later. The names of each Qualified Beneficiary electing COBRA continuation coverage must be listed on the COBRA election form, the coverage being elected must be checked, and the form must be signed by a Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. A parent may elect to continue coverage on behalf of any dependent children. The employee or employee's spouse can elect continuation coverage on behalf of all the Qualified Beneficiaries.

Failure to fully complete and return the election form by the due date will result in the loss of the right to elect COBRA continuation coverage.

If a Qualified Beneficiary initially waives coverage under COBRA, the Qualified Beneficiary may still later elect coverage, provided the election is made within sixty (60) days of the date of the notice, or sixty (60) days after coverage ends as a result of the Qualifying Event, whichever is later. However, coverage will not begin until the date of the election (the date the election form is postmarked, if mailed, or the date faxed).

PAYING FOR CONTINUATION COVERAGE

Generally, each Qualified Beneficiary may be required to pay the entire cost of continuation coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of continuation coverage due to a disability, 150%) of the cost to the group dental plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The first payment for continuation coverage must be made within forty-five (45) days after the date of the election (this is the date the election form is postmarked, if mailed, or the date faxed). If the first payment for continuation coverage is not made in full within that forty-five (45) days, the Qualified Beneficiary will lose all continuation coverage rights under the Plan.

The first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated up to the time the first payment is made. The Qualified Beneficiary is responsible for making sure that the amount of the first payment is correct.

Thereafter, periodic payments can be made on a monthly basis. Each of these periodic payments for continuation coverage is due on the first day of every coverage period, although a grace period of thirty (30) days will be allowed. Continuation coverage will be provided for each coverage period as long as payment for that period is made before the end of the grace period. If a periodic payment is made later than its due date, but during the grace period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is made. Any claims submitted while coverage is suspended may be denied, and will have to be resubmitted when coverage is reinstated.

If a Qualified Beneficiary fails to make a periodic payment before the end of the grace period for that payment, all rights to continuation coverage under the Plan will be lost. The plan will not send periodic notices of payments due.

TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified dental insurance, including continuation coverage. If an individual has questions about these new tax provisions, the Health Coverage Tax Credit Customer Contact Center may be contacted toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at: www.doleta.gov/tradeact/2002act_index.asp.

TERMINATION OF CONTINUATION COVERAGE

Continuation of coverage under this Plan shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires for the corresponding Qualifying Event;

2. The date the individual fails to pay any required contributions in full on time;

3. The date a Qualified Beneficiary becomes covered, after electing continuation coverage, under another group health or dental plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;

4. The date a Qualified Beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;

5. The date this Plan is terminated, though a Qualified Beneficiary may have the right to continue COBRA under another group health or dental plan provided by the Employer to similarly situated employees;

6. The date the employer ceases to provide any group dental plan for its employees; or

7. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

KEEP PLAN INFORMED OF ADDRESS CHANGES

In order to protect an individual's rights under COBRA, it is important that the Plan Administrator be informed of any address changes. Individuals should keep a copy of any notices sent to the Plan Administrator for their records.

COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan as defined below, including this Plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, may equal 100% of the Allowable Expenses defined below.

DEFINITIONS

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

Claim Determination Period: A Calendar or 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.

Plan: Any plan under which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;

2. Any group Hospital service prepayment, group dental service prepayment, group practice or other group prepayment coverage;

3. Group coverage under labor-management trusteed plans, union welfare plans, Employer organization plans or employee benefits plans;

4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

5. Coverage provided through a school or other educational institution; or

6. Coverage under any Health Maintenance Organization (HMO).

ORDER OF BENEFIT DETERMINATION

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits paid by both plans will not exceed 100% of the Allowable Expenses. Neither plan pays more than it would without the Coordination of Benefits provision.

A plan without a Coordination of Benefits provision is always the primary plan. The FIRST rule that applies determines primary carrier and supersedes the following rules. If all plans have a Coordination of Benefits provision:

1. The plan covering the person directly, rather than as an employee's dependent, is primary and the other plans are secondary.

2. Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

   However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

   (a) The plan of the parent with custody pays first;
   (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
   (c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

However, if specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses, and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first.

4. Active/Laid-Off or Retired Employees: The plan which covers that person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) will not apply.

5. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (i.e. COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

6. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

RECOVERY

If the amount of the payment made by this Plan is more than it should have been, the Contract Administrator on behalf of the Plan, has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;

2. Providers of care;

3. Insurance companies; or

4. Other organizations.

PAYMENT TO OTHER CARRIERS

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

SUBROGATION

Benefits are payable only upon the Covered Person's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Covered Person agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

2. To restore to the Plan any such benefits paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for the Injury or condition without obtaining the Plan's written approval; and

4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Covered Person settles, recovers, receives, or is reimbursed by any first or third party or Coverage, the Covered Person agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Covered Person shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such Illness or Injury.

If the Covered Person (or guardian or estate) decides to pursue a first or third party or any Coverage available to them as a result of the said Injury or condition, the Covered Person agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all first or third parties or Coverage, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any Coverage or first or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. This right of subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

REIMBURSEMENT RIGHTS

The Covered Person, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician, or other provider of dental care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of implementing the terms of this Plan, the Contract Administrator retains the right to request any dental information from any insurance company or provider of service it deems necessary to properly process a claim. The Contract Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Contract Administrator such information as may be necessary to implement this provision.

RIGHTS OF COVERED EMPLOYEES (ERISA)

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

RECEIVE INFORMATION ABOUT THE PLAN AND BENEFITS

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

CONTINUE GROUP DENTAL PLAN COVERAGE

Continue dental coverage for the employee, the employee's spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The employee or the employee's dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the Employer, or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising a Covered Person's rights under ERISA.

ENFORCEMENT OF RIGHTS

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

Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, a Covered Person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Person has a claim for benefits that is denied or ignored, in whole or in part, a Covered Person may file suit in a state or federal court, however, a Covered Person must follow the appeal procedures outlined in the Plan before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, a Covered Person may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting their rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person has sued to pay these costs and fees. If a Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If a Covered Person has any questions about this statement or about the Covered Person's rights under ERISA, or if the Covered Person needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa. (Addressees and phone numbers of regional and District EBSA offices are available through EBSA's website.)

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of a claim and all information needed to process the claim must be given to the Contract Administrator as soon as reasonably possible and in no event, later than one year from the date such claim is incurred.

RECORDS

For the purposes of claims administration, each Covered Person authorizes and directs any provider that has attended, examined, or treated them to furnish to the Contract Administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the Covered Person; and the Contract Administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Person.

CLAIM DETERMINATION

Urgent Care Claims: Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than seventy-two (72) hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator shall notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Contract Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Plan's receipt of the specified information; or

2. The end of the period afforded the Claimant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

Pre-Service Claims: Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following an Adverse Benefit Determination. In the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This notification shall be provided to the Claimant or Authorized Representative , as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant or Authorized Representative.

Post-Service Claims: Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

Filing Extensions: The Plan may extend determination on both Pre-Service and Post-Service Claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Contract Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

Concurrent Care Decisions: If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Contract Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the dental exigencies, and the Contract Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Adverse Benefit Determination: The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on dental necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Claimant's dental circumstances, or an explanation will be provided free of charge to the Claimant upon request.

Where the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.

Authorized Representative: The Plan will recognize an Authorized Representative, including a dental care provider, acting on behalf of a Claimant. The Plan will recognize a Health Care Professional with knowledge of a Claimant's dental condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Claimant.

RIGHT OF REVIEW AND APPEAL

A Claimant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Covered Person in the appeal. All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant or an Authorized Representative appeals an Adverse Benefit Determination, the Contract Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:

1. Specific reasons for denial with reference to the Plan Document section(s);

2. A description and need for any other material pertinent to the claim; and

3. An explanation of this Plan's review procedure and the names of any dental professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records, and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Covered Person must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Claimant is deemed to have exhausted the administrative remedies and is free to pursue legal action on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

No legal action involving this Plan or it's administration shall be allowed or brought after the expiration of two (2) years following the date any eligible expense is incurred, or one year following the date of the Adverse Benefit Determination, whichever is the shorter period.

PLAN INTERPRETATION

All decisions concerning the interpretation or the application of this Plan and its terms, shall be at the discretion of the Plan Administrator.

PERIODIC REPORT

Within one month following the date of any change in the group of employees and dependents covered, the Employer shall furnish the Contract Administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any employees or dependents who are eligible for coverage, shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the Employer to report any termination of any employee or dependent, obligate the Plan to continue such benefits beyond the date of termination.

CHOICE OF DENTIST

The Covered Person shall have the free choice of any legally qualified Dentist and the Dentist-patient relationship shall be maintained.

AFFILIATED COMPANIES

Any of the Employer's affiliates, subsidiaries, or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

EMPLOYEE CONTRIBUTION

Participation in this Plan is entirely voluntary. The Employer reserves the right to modify the amount of any employee contributions.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as constituting a contract or other arrangement between the employee and the Employer to the effect that the employee will be employed for any specific period of time.

INSPECTION OF PLAN DOCUMENT

Upon request, the Employer shall make this Plan Document available for inspection by any Covered Person at a reasonably accessible place.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan may be amended or terminated at any time without prior notice and, except as otherwise provided, in any manner, by written authorization and signed by one of the following officers of the Employer: Chief Executive Officer, Chief Financial Officer, President, Vice President, or by any other officer to whom the Employer's Board of Directors delegates the authority to amend the Plan.

It is the intent of this Plan to comply with all applicable Federal and State laws. Wherever this Plan is in conflict with either Federal or State law, the Federal or State law will prevail, unless exempt from either law.

INSTRUCTIONS FOR SUBMISSION OF CLAIMS

All claims submitted should include all of the following:

1. Employee's name, identification number, and home address.
2. If claim is made for a dependent, the dependent's name, Employer and age.
3. Employer's name and group number.
4. Name and address of the Dentist.
5. Dentist's diagnosis.
6. Itemization of charges.

Claims Processing Procedures:

Acceptable claims forms, bills and/or documents:

1. HCFA/UB or ADA Dental Claim Forms; or

2. Superbills - any submitted claim form with all of the following information:

   (a) Detail of procedure performed
   (b) Detailed breakdown of charges
   (c) Diagnosis
   (d) Date of service
   (e) Federal Tax Identification Number (TIN) and address of provider

A claim submitted with all of the above information included will be processed, unless additional information is required to complete the claim. Additional information that may be required to process a claim may include, but is not limited to the following:

1. Coordination of Benefits - Other Insurance Coverage
2. COBRA eligibility
3. Parental custody
4. Legal responsibility for dependent child dental coverage
5. Divorce decree
6. Full-Time Student status
7. Medical history information
8. Injury or accident information.

When the Contract Administrator receives a billing with the required information, the Contract Administrator will process it in accordance with the time frames for Post-Service Claims, Pre-Service Claims and Urgent Care Claims, and in accordance with all other Plan provisions, and in accordance with eligibility and claim information on file. The Contract Administrator will provide a notice of benefit determination or a notice of Adverse Benefit Determination to the Covered Person's designated address.

Please direct all claims and questions regarding claims to:

Meritain Health[sm]
P.O. Box 27267
Minneapolis, MN 55427-0267
(952) 546-0062
(800) 925-2272

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Employer or the Contract Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Dentist (if applicable), and a written reply (which will be kept on file) will be sent.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION 1 - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility;

2. Coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);

3. Coordination of Benefits;

4. Adjudication of health benefit claims (including appeals and other payment disputes);

5. Establishing employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);

10. Dental necessity reviews or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number and name and address of the provider and/or health plan); and

13. Reimbursement to the Plan.

Health care operations include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

5. Conducting or arranging for dental review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

7. Business management and general administrative activities of the Plan, including, but not limited to:

   (a) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
   (b) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

8. Resolution of internal grievances; and

9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

SECTION 2 - THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY

With an authorization, the Plan will disclose PHI to the benefit plans or other separate plans of this Employer.

SECTION 3 - FOR PURPOSES OF THIS SECTION, THE EMPLOYER IS THE PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

SECTION 4 - WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;

2. Ensure that any agents, including a subcontractor and the Contract Administrator, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6. Make PHI available to an individual in accordance with HIPAA's access requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an account of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA; and

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SECTION 5 - ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The Benefits Manager or other authorized representative of the Plan; and/or

2. Staff designated by the Benefits Manager or other authorized representative of the Plan.

SECTION 6 - LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons described in Section 5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

SECTION 7 - NONCOMPLIANCE ISSUES

If the persons described in Section 5 do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

SECTION 8 – SECURITY OF ELECTRONIC PHI

To the extent required by 45 C.F.R. section 164.314(b), except when the only electronic PHI disclosed to the Plan Sponsor is disclosed pursuant to 45 C.F.R. section 164.504(f)(1)(ii) or (iii), or as authorized under 45 C.F.R. section 164.508, the Plan Sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

In accordance with the foregoing, the Plan Sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

2. Ensure that the adequate separation required by 45 C.F.R. section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

4. Report to the Plan any security incident of which it becomes aware.