Dental Choice 1500

Summary Plan Description

COVERAGE TYPE: DENTAL 1500

PLAN ADMINISTRATOR

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SALVASEN
DENTAL CARE PLAN
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LE 11/19/2020

INTRODUCTION

This Summary Plan Description describes the dental benefits available to enrollees of the Salvasen Dental Care Plan. This document summarizes the Plan rights and benefits for covered enrollees and their dependents. By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So, know your plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

When you become a Covered Person, you will have available to you a listing of the participating providers of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm that they continue to participate in the PPO. A telephone number is provided on the front of your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company - website www.loomisco.com contains links to many online provider directories under the *PPO Directory* option. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

SALVASEN
DENTAL CARE PLAN

SCHEDULE OF DENTAL BENEFITS

Plan Year Maximum	
Class I, II, and III Expenses Combined	$1,500 per Covered Person
Plan Year Deductible ***Deductible applies only to Class II and III services.***	
Per Covered Person Per Family	$50 $150
Plan Payment Percent	
Class I-Preventive	100%
Class II-Basic	80%
Class III-Major ***Benefits for Class III-Major services commence 6 months from the effective date.***	50%

PLAN PROVISIONS

Salvasen Dental Care Plan (the "Plan") has been designed to provide all eligible enrollees and covered eligible dependents with a program of Dental Care Protection. The benefit plan is based on the plan year. Deductibles are calculated based on expenses incurred during the 12 months of each plan year.

Coinsurance: The percentage of the charge the Covered Person pays.

Deductibles: A deductible is the amount of covered expenses, which you (“Covered Persons”) must pay before the Plan will pay. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the plan year.

HOW TO FILE A CLAIM

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the specific condition, a specific treatment or service that was rendered or product provided by a qualified provider.

In-Network (PPO) Claims

When you or a covered dependent utilize the services of PPO providers, your involvement in the claims process will be minimal. After you identify yourself as covered through the Salvasen Dental Care Plan, bills incurred for covered expenses under this Plan will be sent directly to the address identified on your dental plan ID card.

When the provider submits their bills, the payment will be sent to the providers directly. You will receive a copy of the Explanation of Benefits showing the payments made and any deductibles or coinsurance involved in the benefits calculation.

Please ensure the PPO Provider has the current billing instructions provided on your identification card. Failure to submit claims properly will result in delayed claims processing.

NonNetwork Claims

When you or a covered dependent have incurred expenses for which you believe reimbursement is due under the terms of the Plan, you must file the necessary documentation with The Loomis Company, P.O. Box 7011, Wyomissing, PA 19610.

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. It is suggested that each time you file a claim the following information is provided:

- Identify yourself by using your Personal Identification Number and the Plan Number as shown on your Identification Card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.

Claim Timely Filing

If you or a covered dependent claim benefits, a proof of claim must be furnished to The Loomis Company within 12 months following the date of loss. If a written claim form is not furnished to the claims processor within 12 months, the claim may be denied or reduced. Benefits are based on the Plan’s provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim.

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant.

If a claim is wholly or partially denied, the Covered Person will be notified in writing, of the determination. The denial notification will state: (1) the specific reason(s) for the denial; (2) refer to the pertinent Plan provisions on which the denial is based; (3) describe any additional information needed to perfect the claim and explain why the additional information is necessary; and (4) describe the Plan's appeal procedures including its time limits.

How To Appeal A Claim Denial

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a dentist or other health professional, you or your representative will be referred to the dentist for the information before the Plan will provide the requested documents directly to you or your representative. Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action.

Adverse Benefit Determination

Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

Compliance with Regulations

It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to

these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

Authorized Representative

A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, enrollee representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Other Important Claims Information

If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding.

Right to Receive and Release Needed Information

Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

Medical Privacy

Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

ELIGIBILITY PROVISIONS

Initial Enrollment Period

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Salvasen Dental Care Plan. If you also desire dependent coverage, you must enroll your eligible dependents. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them at such time.

If you properly enroll in the Salvasen Dental Care Plan, you will be eligible for coverage under the terms of Salvasen Dental Care Plan. The effective date of coverage is shown in the *Important Plan Facts* section.

You may obtain coverage for you and your eligible dependents by completing the enrollment form and contributing any required amounts. Any eligible dependent children may be covered as dependents of one parent but not both.

An eligible dependent shall mean any one or more of the following:

- The lawful spouse of the enrollee under a legally existing marriage.
- Children of the enrollee, who are under the age of 18 including legally adopted children, children legally placed for adoption, step-children and children for whom the enrollee and/or the enrollee's spouse has been appointed guardian by a court of competent jurisdiction.

  Children of a covered dependent child will not be eligible for coverage under this Plan.
- Alternate recipients under qualified medical child support orders (QMCSO) will be covered. Any child of a Covered Person who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan. Under a QMCSO, the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

A **qualified medical child support order** (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved, the type of coverage to be provided and the Plan that provides the coverage. The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

The phrase **child placed with a covered enrollee in anticipation of adoption** refers to a child whom the enrollee intends to adopt, whether or not the adoption has become final, who has not

attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such enrollee of legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

These persons are excluded as dependents: other individuals living in the covered enrollees' home, but who are not eligible as defined; the divorced former spouse of the enrollee; or any person who is on active duty in any military service of any country.

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

Funding

Enrollee Obligations

The coverage afforded to an enrollee by this Plan requires enrollee contributions. If an enrollee elects to enroll dependents under the Plan, the enrollee is responsible for payment of the dependent contributions suitable to cover such enrollment.

TERMINATION OF BENEFITS

Enrollee's coverage will terminate on the earliest of the following dates:

- The date of the termination of the Plan, or the end of the month following the enrollee's termination of participation in the Plan;

- The date it is proven that the enrollee obtained or attempted to obtain benefits or payment for benefits through fraud or intentional misrepresentation of a material fact;

- The end of the period for which the required contributions have been paid if the charge for the next period is not paid when due;

Dependent's coverage will terminate on the earliest of the following dates:

- The date an enrollee's coverage is terminated;

- The last day of the month in which the dependent ceases to meet the definition of a dependent as defined in the Plan.

NOTE: It is the enrollee's responsibility to notify the Plan when the enrollee or a dependent is no longer eligible for benefits. **Failure to notify the Plan will result in coverage being terminated as of the original date of the occurrence. Any claims paid after that date must be reimbursed by the enrollee.**

DENTAL BENEFITS

Predetermination of Benefits

If you or one of your Dependents plans to have dental treatment that costs more than $300, you should ask your Dentist to file for a Predetermination of Benefits. A Predetermination of Benefits is a procedure by which your Dentist submits a Dental Treatment Plan for review before the work starts. The form is reviewed and returned to your Dentist showing the estimated benefit the Plan will pay. This procedure lets you know exactly how much will be covered by the Plan before the work is started.

The Benefits Department will notify the Dentist of the benefits payable under the Plan. The Participant and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedure to be performed, X-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services, or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the contracted rate for an amalgam filling. <u>The patient will pay the difference in cost.</u>

COVERED DENTAL EXPENSES

Class I Services: Preventative and Diagnostic Dental Procedures

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

- Routine oral exams, including the cleaning and scaling of teeth limit of two exams per Covered Person per plan year.
- One bitewing x-ray series every 6 months.
- One full mouth x-ray or panoramic x-ray every 5 years
- One fluoride treatment for Covered Dependent children under age 19 every 12 months.
- Space maintainers for Covered Dependent children under age 19.
- Periodontal maintenance procedures following periodontal surgery.

Class II Services: Basic Dental Procedures

- Amalgam or resin fillings;
- General anesthetics upon demonstration of Medically Necessity;
- Extractions;
- Oral surgery;

Class III Services: Major Dental Procedures

- Inlays, onlays, crowns, laminates and gold foils. Limited to once in a ten year period for the same tooth surface.
- Replacing inlays, onlays and crowns once every 10 years.
- Root canal treatment.
- Periodontal surgery.
- Repair or recement of crowns, inlays, onlays, dentures or bridges.

- Repair or reline of dentures.

- Those services needed to replace one or more natural teeth which were extracted while the person was covered for these benefits:

    (a) Installation of fixed bridgework done for the first time;
    (b) Installation for the first time of a partial or full removable denture;
    (c) Replacing an existing removable denture or fixed bridgework if:
        (i) It is needed because of the loss on one or more natural teeth after the existing denture or bridgework was installed; or
        (ii) It is needed because the existing denture or bridgework can no longer be used and was installed at least 10 years prior to its replacement.
    (d) Replacing an existing immediate temporary full denture by a new permanent full denture when:
        (i) The existing denture cannot be made permanent; and
        (ii) The permanent denture is installed within 12 months after the existing denture was installed.
    (e) Adding teeth to an existing partial removable denture or to bridgework when needed to replace one or more natural teeth extracted after the existing denture or bridgework was installed.
    (f) Denture adjustment limited to once every 12 months.

DENTAL EXCLUSIONS AND LIMITATIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Administrative Fees – Expenses for missed appointments, completion of claim forms or provided medical information to determine coverage, and/or charges for telephone consultations.

Analgesia – Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation.

Appliances – Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.

Congenital or Developmental Condition – The treatment of congenital (hereditary) or developmental (following birth) malformations.

Cosmetic Dentistry – Treatment rendered for cosmetic purposes, except when necessitated by an accidental injury.

Customized Prosthetics – Precision or semi-precision attachments, over dentures or customized prosthetics.

Discoloration Treatment – Any treatment to remove or lessen discoloration except in connection with endodontics.

Duplicate prosthetic devices or appliances.

Effective Date – Charges for courses of treatment that were begun prior to the Covered Person's effective date.

Excess Care – Services that exceed those necessary to achieve an acceptable level of dental care. If the Plan Administrator determines those alternative procedures, services or courses of treatment could be (could have been) performed to correct a dental condition, benefits will be provided for the least costly procedure(s) that would produce a professionally satisfactory result.

Excess Charge – Charges in excess of the Usual, Customary and Reasonable charge for dental services or supplies.

Experimental Procedures – Services that are considered experimental or that are not approved by the American Dental Association.

Illegal Acts – Charges for an injury or illness caused wholly, partially, directly or indirectly by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. In compliance with the Health Insurance Portability and Accountability Act, if an

injury results from a medical condition or act of domestic violence, the plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

Lost or Stolen Prosthetics or Appliances – Replacement of a prosthetic or any other type of appliance that has been lost, misplaced or stolen.

Myofunctional Therapy – Muscle training therapy or training to correct or control harmful habits.

No Charge – Charges for which the Covered Person and/or the Plan are not legally required to pay, including charges, which would not have been made if no coverage existed. This exclusion is subject to the right, if any, of the United States Government to recover reasonable and customary charges for care provided in a military or veterans' Hospital.

No Fault Auto Accidents – Expenses incurred for the treatment of injuries resulting from a motor vehicle accident to the extent such expenses are eligible for payment under the personal injury protection or compulsory medical payments provisions of a motor vehicle insurance contract or under similar provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment is made under the motor insurance contract.

Not Medically Necessary – Charges that are determined not to be medically necessary.

Not Specified as Covered – Services, treatments and supplies that are not specified as covered under this Plan.

Occlusal Restoration – Procedures that are performed to alter, restore or maintain occlusion including:

- Increasing the vertical dimension;
- Replacing or stabilizing tooth structure lost by attrition;
- Realignment of teeth;
- Gnathological recording or bite registration or bite analysis;
- Occlusal equilibration.

Occupational and/or Work Related – Enrollee or dependent 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). Further the Plan excludes all expenses for which the Covered Person (enrollee or dependent) would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation. This applies even if the Covered Person's rights have been waived or qualified.

Oral Hygiene Counseling – Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks and mouthwashes.
Relative Providing Services – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the enrollee, enrollee's spouse, child, brother, sister or parent, whether the relationship is by blood or exists in law.

Replacement – Charges for a partial or full removable denture, a removable bridge or fixed bridgework, or a crown or gold restoration.

Sealants

Self-Inflicted – For any intentionally self-inflicted injury or illness. In compliance with the Health Insurance Portability and Accountability Act, if an injury (including self-inflicted injury) results from a dental condition or act of domestic violence, the Plan will not deny benefits for the injury.

Services Before or After Coverage – Charges for services and/or supplies provided before the effective date of coverage under the Plan, or provided after termination of coverage under the Plan.

Temporomandibular Joint Disorders (TMJ) – Charges for care and treatment of jaw joint conditions, including temporomandibular joints (TMJ).

Third Party Liabilities – Any expenses caused by a third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company (Please refer to the Coordination of Benefits and Subrogation sections).

War – Treatment of injury or illness that is occasioned by insurrection of war or any act of war, whether declared or undeclared**.**

DEFINED TERMS

Amendment (Amend) – A formal document signed by the representatives of Salvasen Dental Care Plan. The amendment adds, deletes, or changes the provisions of the Plan and applies to all Covered Person, including those persons covered before the amendment becomes effective, unless otherwise specified.

Assignment of Benefits – Authorization by the enrollee for the Plan to pay benefits directly to the provider of the service.

Covered Entity – In terms of the HIPAA Privacy Regulations a Covered Entity includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

Covered Expenses – Those expenses charged by a covered provider and medically necessary for the treatment of illness or injury.

Covered Person – An enrollee or dependent covered under this Plan.

Dental Hygienist - A person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Dentist - A legally qualified dentist or a legally qualified physician authorized by their license to perform, at the time and place involved, the particular dental procedure rendered by them.

Enrollment Date – First day of coverage, or first day of waiting period if there is a waiting period.

ERISA – The Enrollee Retirement Income Security Act of 1974, as amended.

Fiduciary – The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named fiduciary for this Plan is the Plan Administrator for Salvasen Dental Care Plan.

HIPAA- The Health Insurance Portability and Accountability Act of 1996.

Individual Dental Plan – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463).

Medically Necessary (Medical Necessity) – Care and treatment recommended or approved by a physician, which is consistent with the patient's condition and accepted standards of medical

practice, medically proven to be effective treatment of the condition, not performed solely for the convenience of the patient or provider, not conducted for investigative, educational, experimental or research purposes, and is the most appropriate level of service that can be safely provided to the patient. The fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

Physician – Physician shall mean a legally qualified and licensed Doctor of Dentistry (D.M.D. or D.D.S.)

Plan – Salvasen Dental Care Plan, which is a benefits plan for enrollees and is described in this document.

Plan Administrative Functions – Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or between Covered Entities or Business Associates of a Covered Entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Plan Sponsor – Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002 (16)(B).

Plan Year – The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Preferred Provider Organization (PPO) - A company that contracts with a selected group of Hospitals and physicians (preferred providers) offering quality care. Utilization management techniques are applied to covered services. The Plan pays network providers on a fee-for-service basis, usually at discounted rates. The Plan is designed to provide financial incentives in the form of increased benefits to members utilizing preferred providers.

Protected Health Information – Information that is created or received by Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

Qualified Medical Child Support Order – An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction that requires a non-custodial parent to provide medical coverage for his or her child who might not otherwise be eligible for coverage. A qualified order includes information regarding: 1) The Covered Person's name and address; 2) The name and last known mailing address of the alternate recipient (i.e., the child); 3) The name of the Plan the child will be covered by; 4) A reasonable description of the type and scope of health coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate who is presiding over the divorce. The enacted Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provides for the recognition of qualified medical child support orders (QMCSO) by group health plans.

Recovery – Monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Reimbursement – Repayment to the Plan for medical or dental benefits that it has advanced toward care and treatment of the injury or sickness.

Subrogation – The Plan's right to pursue the Covered Person's claims for medical or dental charges against the person causing injury.

Usual, Customary and Reasonable (UCR) – Usual means the provider's most frequent charge for the service or treatment. **Customary** means the charge made, for the same service in the same area, by other physicians or medical service providers with similar training and experience. **Reasonable** means the medical care or supplies; usually given and the fee usually charged for the cases in that area. The Plan will reimburse the actual charge billed if it is lesser than the usual and reasonable charge. The Plan Administrator has the discretionary authority to decide whether a charge is usual, customary and reasonable.

GENERAL PROVISIONS

Administration - This plan of benefits is administered through the Salvasen Dental Care Plan. As Plan Administrator, Salvasen Dental Care Plan shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matter arising under the Plan, based on the applicable facts and circumstances. The Loomis Company has been retained to provide independent services in the area of claims processing.

Assignment of Benefits – In the event a Plan participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan participant's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of Salvasen Dental Care Plan.

Plan Amendment or Termination – Salvasen Dental Care Plan reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Sponsor. If the Plan is amended, modified, suspended, withdrawn, discontinued or terminated, covered enrollees and covered dependents will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles and/or co-payments, and (4) change the class of enrollees or dependents covered by the Plan.

Medical Care Decision - The benefits under the Plan provide solely for the payment of certain dental care expenses. All decisions regarding dental care are solely the responsibility of each Covered Person in consultation with the dental care providers selected. The Plan contains rules for determining the percentage of allowable dental care expenses that will be reimbursed, and whether particular treatments or dental care expenses are eligible for reimbursement. The Covered Person in accordance with the Plan's appeal procedures may dispute any decision with respect to the level of dental care reimbursements, or the coverage of a particular dental care expense. Each Covered Person may use any source of care for dental treatment and dental coverage as selected, and neither the Plan nor the enrollee shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

RIGHTS AND PROTECTIONS

The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Covered Persons and beneficiaries.

If there are any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about rights, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210.

LEGISLATIVE COMPLIANCE

All provisions of the Plan shall at all times be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable governmental laws, statutes, regulations, or rules promulgated by any governing unit having appropriate jurisdiction. The Plan Administrator shall administer the Plan accordingly, as well as complying with any changes to such statutes, regulations or rules affecting these provisions.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status related factors, (physical or mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of coverage under the Plan, for determining the level of contribution to Plan funding, or to determine the level of benefits which will be made available to a person. All Plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

No provision contained in this booklet nor any portion of the Plan shall give a Plan participant or entity acting on their behalf any right or cause of action, either at law or in equity against the Plan Administrator, the Third Party Administrator, the Plan Sponsor, for the acts of any physician, or other provider from whom services are received and benefits are provided under this Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI and we must abide by the terms of this Notice. We reserve the right

to change the provisions of our Notice and make the new provisions effective for all PHI we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact the Plan Administrator.

Effective Date: This Notice of Privacy Practices becomes effective on April 14, 2004.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Payment: We may use or disclose your PHI to pay claims for services provided to you and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI when a provider (doctor, Hospital, clinic, etc.) requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations: We may use or disclose your PHI to support our business functions. These functions include, but are not limited to: medical care, quality assessment and improvement, stop-loss insurance underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with information about one of our health management programs; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

Business Associates: We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide their services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Personal Representatives: We may disclose PHI to the patient or the patient's personal representative. A personal representative is a legal guardian, or a person designated by you to act on your behalf in making decisions related to your health care.

Public Health Activities: We may disclose PHI to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability.

Abuse or Neglect: If we believe you are the victim of abuse or neglect, we may disclose PHI to a government authority such as social services or protective services agency.

Health Oversight Activities: We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance.

Legal Proceedings: We may disclose PHI in the course of a judicial or administrative proceeding in response to legal order or other lawful process.

Law Enforcement Officials: We may disclose PHI to the police or other officials in compliance with a court order or subpoena.

Organ & Tissue Procurement: We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Coroners: We may disclose PHI to a medical examiner as authorized by law.

Specialized Government Functions: We may use and disclose PHI to units of the government with special functions such as the U.S. military or the U.S. Department of State.

Workers' Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Health & Safety: We may use and disclose PHI, if in good faith, we believe it is necessary to prevent or lessen a serious and imminent threat to the health & safety of a person or the public.

As Required by Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

To the Plan Sponsor: We may disclose your PHI to the plan sponsors of the group health plan for purposes of plan administration.

Others Involved in Your Care: We may disclose your PHI known to a family member, relative or close personal friend that you identify. Such a use will be based on how involved the person is in

your care. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

YOUR RIGHTS

Right to Request a Restriction: You have the right to request a restriction on the PHI we use or disclose about you for claim payment or healthcare operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe that a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a "designated record set." A "designated record set" contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than claim payment or health care operations. No accounting of disclosures is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of claim payment or health care operations, and, therefore, will not be subject to your right to an accounting.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice, even if you may have agreed to accept this Notice electronically.

HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Sponsor becomes aware.

NO VERBAL MODIFICATIONS

The Covered Person shall not rely on any oral statement from The Loomis Company which modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan and increases, reduces, waives or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from Salvasen Dental Care Plan is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

This booklet is not a contract. It explains in nontechnical language the essential features of your Benefit Program.