PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR ARAZ GROUP DE, LLC

DENTAL PLAN

Amended & Restated January 1st, 2025

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Establishment of the Plan; Adoption of the Plan Document and Summary Plan Description

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Araz Group DE, LLC (the "Company" or the "Plan Sponsor") as of January 1, 2025, hereby sets forth the provisions of the Araz Group DE, LLC Dental Plan (the "Plan").

Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

ARAZ GROUP DE, LLC

By: Jeffrey J Bakke

Name: Jeffrey J Bakke

Title: CEO

Date: 1/22/2025

General Plan Information

Name of Plan:	ARAZ GROUP DE, LLC Dental Plan
Plan Sponsor:	ARAZ GROUP DE, LLC 7201 W. 78th St. Suite 100 Minneapolis, MN 55439
Plan Administrator: **(Named Fiduciary)**	ARAZ GROUP DE LLC, 7201 W. 78th St. Suite 100 Minneapolis, MN 55439 952-896-9104
Plan Sponsor ID No. (EIN):	85-1591524
Source of Funding:	Self-Funded
Applicable Law:	This Plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). To the extent not preempted by Federal law, the Plan shall be governed by MN law.
Plan Year:	January 1st to December 31st
Plan Number:	501
Plan Type:	Dental Plan
Third Party Claims Administrator	America's TPA, LLC d/b/a HealthEZ P.O. Box 211186 Eagan, Minnesota 55121 952-896-9104
Participating Employer(s):	ARAZ GROUP DE, LLC
Agent for Service of Process:	ARAZ GROUP DE, LLC 7201 W. 78th St. Suite 100 Minneapolis, MN 55439 952-896-9104

Introduction

This document is a description of Araz Group DE, LLC Dental Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain preventive, basic and catastrophic dental expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, failure to pay premiums on time or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

HIPAA Privacy Rights. Explains your rights under the Health Insurance Portability and Accountability Act.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

Eligibility, Funding, Effective Date, and Termination Provisions

If you have any questions about your Dental Plan or any of the benefits, do not hesitate to contact HealthEZ at 952-896-9104.

Eligibility	
Waiting Period	The coverage Effective Date for an Employee is the first day of the month following 30 days of employment
Full Time Requirements	30 hours per week or 130 hours per month
Dependent	1. An Employee's Spouse; 2. An Employee's Child who is less than 26 years of age, without regard to the child's student or marital status or whether the child is the Employee's financial dependent; 3. An Employee's Child, regardless of age, who became Disabled prior to the end of the month in which the Child attained 26 years of age. For purposes of this section, a Child is considered "disabled" if he or she meets the criteria used by the Social Security Administration to determine disability for purposes of the Supplemental Security Income program. The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.
Termination	Last day of the month that the member becomes ineligible.
Rehired Employees	If an Employee is rehired within 13 weeks of their termination, they are eligible no later than the first of the month following that rehire.
Deductibles	
Deductible Year	Calendar
Are there individual deductibles on a family plan?	Yes

PLAN CONTRIBUTIONS AND FUNDING

The Plan is self-funded by the general assets of the Plan Sponsor, which may include contributions from employees. The Plan Sponsor determines the level of Employee contributions, if any, and the method of payment. Contact the Plan Sponsor with any questions.

ENROLLMENT

An Employee must enroll for coverage with the Plan Sponsor within 30 days after the Employee becomes eligible to participate in the Plan. After this period, the enrollment decision cannot be changed or dropped during the Plan Year without a qualifying life event. During Open Enrollment, Employees will be able to elect, change, or discontinue coverage.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other dental insurance or group dental plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

SPECIAL ENROLLMENT RIGHTS- QUALIFYING LIFE EVENT

Usually, You may only make coverage changes during Open Enrollment. However, federal law allows a special enrollment period if You experience certain qualifying life events. In these cases, coverage will be effective on the date of the qualifying life event, provided a request for enrollment is made within 30 days of the qualifying life event, unless a longer time is provided in this Plan Document or required by law. An Employee or Eligible Dependent who is already enrolled in the Plan at the time of the qualifying life event may also make changes to their enrollment at this time.

The following are considered qualifying life events under the Plan for purpose of this special enrollment right:

- Loss of other coverage:
    - Losing eligibility for existing health coverage, including job-based, individual, and student plans.
    - Losing eligibility for Medicaid or CHIP or becoming eligible for a state premium assistance subsidy under Medicaid or CHIP.

      If an Employee has declined enrollment in the Plan for themselves or Dependents because of coverage under Medicaid or CHIP and loses that coverage or becomes eligible for a state premium assistance subsidy under Medicaid or CHIP, there is a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the Medicaid or CHIP coverage ends or after becoming eligible for a state premium subsidy under Medicaid or CHIP.
- Changes in household:
    - Acquisition of a new spouse due to marriage.
    - Acquisition of a new Dependent through marriage, birth, adoption, or placement for adoption.

IMPORTANT NOTICE: IF YOUR OTHER DENTAL PLAN COVERAGE WAS LOST BECAUSE OF A FAILURE TO PAY COVERAGE PREMIUMS OR OTHER REQUIRED CONTRIBUTIONS, YOU DO NOT HAVE SPECIAL ENROLLMENT RIGHTS BASED ON THE LOSS OF THAT COVERAGE.

COVERAGE DURING DISABILITY OR LEAVE OF ABSENCE

A Plan Participant may remain eligible under the Plan for a limited time if disabled or during a leave of absence, such as FMLA leave. You may request further information from your Employer.

EMPLOYEES ON MILITARY LEAVE

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), if an Employee is absent from work because of service in the uniformed services, the Employee can continue health coverage for the Employee and the Employee's covered Dependents. If the Employee or the Employee's covered Dependents choose coverage under USERRA, then the Employee or the Dependents must pay monthly premiums for coverage.

During a military leave that is expected to be 30 days or less, the Employee's current employee coverage will continue without interruption, assuming the Employee pays the normal share of premiums for the coverage.

While on paid military service leave (for up to two years), the Employee may maintain the health benefits for which the Employee was enrolled before military service leave by paying the Employee's normal share of premiums for coverage.

For Employees who continue coverage while in military service, coverage will terminate at the earliest of these dates:

- The 24-month period beginning on the date absence begins; or
- The date the Employee fails to return to work as required.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, unless on active duty for 30 days or less.

A Waiting Period may not be imposed upon reemployment if one would not have been imposed had coverage not been terminated because of military service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of active military service.

After your paid military service leave ends, the Employee may elect continuation coverage for up to 24 months under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. Dependents do not have any independent right to elect USERRA health plan continuation.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage begins on the date assigned; this is on the coversheet at the beginning of this document. You must meet the following three requirements:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

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

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

TERMINATION OF COVERAGE

The Plan Sponsor has the right to rescind any coverage for cause, including making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan Sponsor may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

(1) The date the Plan is terminated.

(2) The day the covered Employee ceases to be in one of the Eligible Classes (see Eligibility Setup on page 2). This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)

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

(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

(5) If applicable, at a time designated by the Employer following the end of the Stability Period for Variable Hour Employees, if the Employee failed to qualify during the previous Measurement Period.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

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

(2) The date that the Employee's coverage under the Plan terminates (see eligibility matrix on page 2) for any reason including death. (See the COBRA Continuation Options.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CLERICAL ERROR

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

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

Schedule of Benefits

Deductibles payable by Plan Participants. Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services.

	Dental Plan
Deductible	**Per Calendar Year**
Employee Only	$50
Employee + Spouse/Employee + Child(ren)	$75
Family	$100
Annual Maximum	$2,000
Life Time Orthodontic Maximum (Max age of 16, no coverage for Orthodontics over age 16)	$2,000

	Coverage
Preventive Health Care Dental Exams - two per Plan Year Cleanings- two per Plan Year Fluoride Treatments (children under age 18) - two per Plan Year Bitewing Xrays - two per Plan Year Occlusal Xrays – one per Plan Year Space Maintainers (children 15 and under)	100% Coverage Deductible does not apply
Panoramic Xray - one per 36 month period	
Sealants – up to age 16, permanent molar teeth, limited to once per 36 month period	
Amalgam & Composite Fillings	10% Coinsurance After Deductible
Basic Care Anesthesia Emergency Palliative Treatment Surgical Extractions Pathology Periodontics- Debridement and Exams Periodontal Maintenance – once per 3-month period Endodontics – Root Canal, Root Canal Filling, Pulp Vitality Tests Occlusal Guard – one per 5-year period Other Oral Surgery	20% Coinsurance After Deductible

Major Care Crowns, Inlays, Onlays, Pontics, Bridges, Implants, Bridgework, Dentures and other eligible services	50% Coinsurance After Deductible
Orthodontic Services Max age of 16, no coverage for Orthodontics over age 16.	50% Coinsurance After Deductible

Notes: All charges are subject to Usual and Customary pricing at the 90th percentile

DENTAL BENEFITS

Dental Benefits apply when Covered Charges are incurred by a Plan Participant for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Plan Participant. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Plan Participant.

COVERED CHARGES

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

Covered Dental Services

Covered Dental Services which are performed or supervised by a Dentist and provided to a Covered Individual shall be payable as indicated in the Schedule and are deemed to include:

A – PREVENTIVE & DIAGNOSTIC SERVICES

1. Initial, Periodic or Diagnostic Oral Examinations. Limited to two (2) per Plan Year.

2. Prophylaxis and /or periodontal maintenance. Cleaning and scaling of teeth. Limited to two (2) per Plan Year.

3. Radiographs/X-Rays. Dental x-rays, intraoral or bitewings. Bitewing X-rays limited to two (1) per Plan Year. Occlusal X-rays limited to one (1) per Plan Year.

4. Panoramic (Panorex) x-rays. Limited to one (1) x-ray in any 36-month period.

5. Space Maintainers, for dependents to age fifteen (15) to replace primary teeth.

6. Topical application of fluoride (excluding prophylaxis) for dependent children under the age of 18. Limited to two (2) treatments per Plan Year.

7. Sealants on the occlusal surface of a posterior permanent tooth for dependent children to age sixteen (16), limited to once in any 36-month period.

B – BASIC SERVICES including Basic Restorations, Endodontics, Periodontics and Oral Surgery.

1. Consultations

2. Study models

3. Fillings: amalgam, acrylic, plastic or composite fillings including pin retention when necessary.

4. Oral Surgery - Limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than ¼ of an inch. Includes extractions and general anesthesia relative to such surgical services.

5. Endodontic Services including Root Canal Therapy

6. Palliative (emergency) treatment of dental pain. Any x-ray taken in connection with such treatment is considered a separate dental procedure.

7. Pulp vitality testing. Limited to once annually unless specific need exists for emergency diagnosis.

8. Periodontic treatment or surgery to remove diseased gun tissue or bone.

9. Periodontic maintenance. Limited to one in any 3-month period.

10. Occlusal adjustments, only in conjunction with periodontal surgery, 4 quadrants per treatment plan. Limited to once in any 24-month period.

11. Occlusal night guards are limited to one in any 5-year period.

12. General anesthesia when medically necessary and administered in connection with a covered oral surgical procedure.

13. Nitrous oxide.

C – MAJOR SERVICES including Major Restorations, Dentures, Bridgework and Prosthodontic Repairs

1. Repair or re-cementing of crowns, inlays, denture or bridgework.

2. Relining and Rebasing for full or partial dentures

3. Crowns, inlays and onlays and gold restorations.

4. Installation of precision attachments for removable dentures.

5. Initial installation of partial or full removable dentures including adjustments for the six (6) consecutive month period following installation.

6. Initial installation of fixed bridgework including crowns and inlays to form retainers. Benefits area available only when the initial installation is to replace one (1) or more natural teeth extracted while you are covered under the Plan.

7. Replacement of an existing partial or full removable denture, or fixed bridgework, by a new partial or full removable denture or new fixed bridgework. Benefits are available only when the replacement includes one (1) or more natural teeth extracted while you are covered under this Plan or the existing denture or bridgework is a least five (5) years old.

8. The addition of teeth to an existing partial removable denture or existing fixed bridgework.

9. Implants and implant-related services.

D – ORTHODONTIC SERVICES (Max age of 16, no coverage for orthodontics over age 16.)

Placement of Orthodontic Appliances and related services are covered. Such services **include** diagnosis, examination, preliminary study, cephalometric x-rays and period adjustments. Expenses for these covered dental services are eligible only to the extent that they are provided in connection with Orthodontic Treatment for one or more of the following conditions.

1. Cephalometric x-rays;

2. Diagnostic casts for orthodontic purposed;

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.

Plan Exclusions

For all Dental Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) 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) **Acupuncture.**

(3) **Appliances** to control harmful habits, except as specified in Covered Dental Expenses.

(4) **Athletic mouth guards.**

(5) **Bite registrations**

(6) Charges for completion of any **claim forms.**

(7) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(8) Dental Services provided primarily for **cosmetic** purposes except following an accidental injury that occurred while the individual was covered under this Plan and provided such services are rendered within 12 months of such injury.

(9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge. Charges in excess of the maximum benefit payable.

(10) Services or supplies which do not meet accepted standards of dental practice as adopted and accepted by the American Dental Association (ADA), including charges for services and supplies which are **experimental** in nature.

(11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(12) **Government coverage.** 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).

(13) Expenses for treatment at a facility owned and 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.

(14) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating or bungee jumping.

(15) **Hospital** expenses will not be considered eligible.

(16) **Hypnosis.**

(17) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is

not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(18) Expenses for **installation, replacement** or alteration of, or addition to, dentures or fixed bridgework will not be considered eligible, except as shown in Covered Dental Expenses.

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

(20) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(21) Expenses which do not meet the standards of dental practices accepted by the American Dental Association, or for services **not prescribed as necessary by the physician or Dentist** will not be considered eligible.

(22) **Not specified as covered.** Non-traditional dental/medical services, treatments and supplies which are not specified as covered under this Plan.

(23) Charges for failure to keep a scheduled dental **office appointment**.

(24) **Orthodontics services** and related services unless listed under the Summary of Dental Benefits as a covered service.

(25) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(26) **Prescription** drugs and medicines.

(27) Charges for **Prophylaxis, Topical Fluoride Treatments and Oral Examinations** which are provided before the time restrictions as defined in the schedule of benefits

(28) Charges for duplicate prosthetic devices or the **replacement** of dentures, bridges or prosthetic devices less than three years old except as specifically provided in the Schedule.

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

(30) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan. This includes crowns, inlay or onlay restoration if the tooth was prepared before the individual became covered under the plan. Denture and/or bridgework, including crowns and inlays forming abutments, if the first impressions are taken and/or abutment teeth are fully prepared before the individual becomes covered under the plan.

(31) **Sign Language.** Professional sign language or foreign language interpreter services in a dental office.

(32) Charges for the replacement of lost or **stolen** dentures, bridges or prosthetic devices.

(33) Charges for a **temporary** full prosthesis or for adjustment or relining of prosthesis within six months after the prosthesis is initially furnished will not be considered eligible.

(34) Charges for the application of orthotic appliances and other non surgical services for the treatment of **Temporomandibular Joint Dysfunction (TMJ)** or any other cranial facial or cervical spine syndrome.

(35) Charges for **training,** educational instruction, or materials relating to dietary counseling, personal oral hygiene, or dental plaque control.

(36) **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician or Dentist.

(37) **Veneers,** except as specified in Covered Dental Expenses.

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

(39) Dental Services for which benefits are received (or could be received if a claim were made) under any **Workers Compensation Law** or similar legislation, or charges for dental treatment or services which are rendered under any municipal, county, state, federal or other governmental agency, law or regulation for which a charge is not imposed.

How to Submit a Claim

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

Send bills for services rendered to Claims Administrator. All claims must include :

- Name of Plan;
- Employee's name;
- Subscriber Number;
- Patient’s name;Name, address, tax ID, and telephone number of the provider of care;
- Type of services rendered, with diagnosis and/or procedure codes;
- Date of service(s);
- Any Receipt.

The Claim should be sent to HealthEZ through one of the following methods:

Mail – PO Box 211186, Eagan, MN 55121
Email – claimsubmission@healthez.com

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one yaer from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims 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. The Plan reserves the right to have a Plan Participant seek a second opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

(a) the specific reason or reasons for the denial;

(b) specific reference to those Plan provisions on which the denial is based;

(c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final

decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits, these Claims procedures are intended to comply with Section 503 of ERISA and the regulations issued thereunder. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining dental care.

In the case of a Pre-Service Claim, the following timetable applies:	
Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered dental services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:	
Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to the Plan Participant of Adverse benefit determinations

If a Claim is denied, in whole or in part, the denial is considered an Adverse benefit determination. Except with Urgent Care Claims, HealthEZ will provide written or electronic notification of the Adverse benefit determination. For Urgent Care Claims, notification may be made orally and followed by written or electronic notification within

three days of the oral notification. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant the following information:

- A reference to the specific portion(s) of the plan upon which a denial is based;
- Specific reason(s) for the adverse determination;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse benefit determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- If the Adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- In the case of an Adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

Appeals

When a Plan Participant receives an adverse benefit determination, the Plan Participant has 180 days following receipt of the notification in which to appeal the decision. A Plan Participant may submit written comments, documents, records, and other information relating to the Claim. If the Plan Participant requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

- Was relied upon in making the adverse benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- Demonstrated compliance with the administrative processes and safeguards required and designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Appeals should be submitted to **Araz Group DE, LLC at 7201 W. 78th Street, Suite 100, Bloomington, MN 55439**: The decision timeline begins at the time an appeal is filed without regard to whether all the necessary information accompanies the filing.

The review shall take into account all information submitted by the Plan Participant relating to the Claim. The review will not afford deference to the initial adverse benefit determination and will be conducted by the named fiduciary of the Plan, or a delegate of the named fiduciary, who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination is based, in whole or in part, on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgement. The identification information for the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the determination, will be provided. Also, the health care professional engaged for purposes of consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is subject to the appeal, nor the subordinate of any such individual.

In the case of a Claim involving urgent care, there is an expedited review process pursuant to which: (a) a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and (b) all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method.

If the Appeal of a Claim is denied, in whole or in part, the claimant will be provided written notification of the adverse benefit determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant, the following:

- The specific reason(s) for the adverse determination;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures and a statement of the claimant's right to bring action under Section 502(a) of ERISA;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Legal proceedings may be initiated against the Plan after the appeals process has been exhausted.

Defined Terms

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

CALENDAR YEAR: January 1 through December 31 of each year. Except for an individual's initial participation in the Plan, then the Calendar Year will commence on the effective date of coverage and end on December 31.

CHILD: Employee's own blood descendant of the first degree, a stepchild, lawfully adopted Child, or a Child placed with a covered Employee in anticipation of legal adoption, and/or a covered Employee's Child who is an alternate recipient under a "Qualified Medical Child Support Order" required by law.

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

COVERED PERSON: is an Employee or Dependent who is covered under this Plan.

DEDUCTIBLE: Is the total amount of Eligible Expenses for covered Diagnostic Services which must be incurred by the Covered Individual during any Calendar Year before Dental Benefits are payable for such services under the Plan.

DENTAL HYGIENIST: A person who is duly licensed to practice Dental Hygiene by and qualified under the laws of the State in which his services are rendered **provided** such hygienist works for and under the supervision and direction of a Dentist.

DENTAL SERVICE: Any Service or class of services or supply provided to a Covered Individual for the dental diagnosis, treatment or care to the extent described under this Plan.

DENTIST: Any Doctor of Medicine (MD), Dental Surgery (DDS) or Dental Medicine (DDM) and Dental Hygienists for eligible dental services, which they personally perform. The Dentist must be duly licensed and qualified under the laws of the State in which such eligible dental services are performed.

ELIGIBLE EXPENSE: A covered Dental Service to which the Usual & Customary Charge criteria is applied to determine the allowable amount before Benefits are applied and paid.

EMPLOYEE: A person who is employed by the Plan Sponsor and eligible for coverage.

EMPLOYER: Araz Group DE, LLC and its affiliated companies.

ENROLLMENT DATE: The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

EXPERIMENTAL AND/OR INVESTIGATIONAL: Services, supplies, care and treatment which do not constitute accepted dental practice properly within the range of appropriate dental practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

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

(1) a drug, device, dental treatment or procedure is experimental or investigational if the drug or device, medical treatment or procedure cannot be lawfully marketed or performed without approval of the

U.S. Food and Drug Administration and approval for marketing or performance has not been given at the time the drug, device, medical treatment or procedure is provided;

(2) drugs are considered experimental if they are not commercially available for purchase, and/or they are not approved by the Food and Drug Administration for general use;

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

(4) if Reliable Evidence shows that the drug, device, dental treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

FAMILY UNIT: The covered Employee and the family members who are covered as Dependents under the Plan.

FOSTER CHILD: An individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

A covered Foster Child is not a child temporarily living in a covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

INJURY: An accidental physical Injury to the body caused by unexpected external means.

LATE ENROLLEE: A Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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.

PLAN: Araz Group DE, LLC Dental Plan which is a benefits plan for certain employees of Araz Group DE, LLC and is described in this document.

PLAN PARTICIPANT: Any Employee or Dependent who is covered under this Plan.

PLAN YEAR is the 12-month period beginning on either the effective date of the Plan.

PRE-DETERMINATION: The pre-Treatment review is to determine the eligibility of the individual and the coverage for services in accordance with the Schedule of Benefits.

PRESCRIPTION DRUG: A Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin;

hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

SPOUSE: An individual who is lawfully married to an Employee under the laws of the state where the Employee resides.

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

TOTAL DISABILITY or TOTALLY DISABLED: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

TREATMENT PLAN: Is a written report showing the recommended treatment of any dental disease, defect or injury, which is prepared by a Dentist as the result of his examination of an individual while covered under this Plan.

USUAL AND REASONABLE CHARGE: Covered Expenses which are identified by the Plan Administrator or its delegate, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates.

The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of a person of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator or its delegate will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

The Plan will reimburse the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

WAITING PERIOD: The time between your date of hire and the date that you are eligible for medical benefits under the Plan.

Coordination of Benefits

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

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

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

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

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

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of

a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

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

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work in accordance with HIPAA regulations, this Plan may give or obtain needed information from another insurer or any other organization or

person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

As a condition to participating in and receiving benefits under this plan, covered persons and their dependents (Plan Beneficiary) agree:

1. 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 insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds ("Coverage") for which the Plan Beneficiary claims an entitlement to benefits under this plan, regardless of how classified or characterized and to reimburse the plan for any such benefits paid when recovery is made.

2. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Plan Beneficiary for the injury or condition without obtaining the Plan's written approval; and in the event a Plan Beneficiary settles, recovers or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition. The Plan Beneficiary acknowledges that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Plan Beneficiary as the result of the illness or injury, regardless of whether the Plan Beneficiary is made whole. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Plan Beneficiary will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recovery such money from the Plan Beneficiary. If the Plan Beneficiary decides to pursue a third party or any Coverage available to he/she as a result of the said injury or condition, the Plan Beneficiary agrees to include the Plan's Subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Plan Beneficiary decides not to pursue any third parties or Coverage the Plan Beneficiary 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 Plan Beneficiary 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. The Plan Beneficiary 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 Plan Beneficiary pursuing a claim against any Coverage. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. If the injury or condition giving rise to subrogation involves a minor child or wrongful death of a Plan Beneficiary, this provision applies to the parents or guardian of the minor Plan Beneficiary and the personal representative of the deceased Plan Beneficiary. The Plan's remedies shall be equitable in nature and recovery may be made through the imposition of a constructive trust on a Plan Beneficiary's recovery.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

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 (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

COBRA Continuation Options

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(i) The death of a covered Employee.

(ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's enrollment in the Medicare program.

(v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. [Delete upon expiration of public health emergency]]Note that the election period rules described above have been impacted by COVID Tolling rules described earlier in the Plan document.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(i) The last day of the applicable maximum coverage period.

(ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

(vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan,

covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? No conversion option is available under this Plan.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, please keep your Employer and HealthEZ informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Employer or HealthEZ.

Employee Retirement Income Security Act (ERISA)

Plan Administration

The Plan Administrator, who is listed on the inside front cover of this brochure, is a named fiduciary under the Program and shall be responsible for the management and control of this Program. The Plan is a self-funded benefit plan under ERISA.

The Plan Administrator is responsible for determining the level of benefits for the Program as described in this brochure. The Plan Administrator reserves the power at any and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the code or ERISA) to modify or amend, in whole or in part, any or all provisions of the Plan, provided, however, that no modification or amendment shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

Funding Policy and Payment

The funding policy and method requires that the Group Subscriber submit payments on a monthly basis.

Procedure to Request Information

If you have any questions about this Program, contact the Plan Administrator who is listed in the inside front cover of this brochure.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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 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. this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Continue Group Health Plan Coverage

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

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 Plan. 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 other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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

Assistance with your Questions

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

Important Notices

GINA NOTICE

The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), prohibits discrimination on the basis of Genetic Information. GINA expands on HIPAA in several ways:

- Group health plans and health insurers cannot base premiums on Genetic Information;
- Plans and insurers are prohibited from requesting or requiring an individual to undergo a genetic test; and
- Plans and insurers are prohibited from collecting Genetic Information (including family history) prior to or in connection with enrollment, or for underwriting purposes.

MENTAL HEALTH PARITY

The Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), enforce parity between covered health care benefits and covered mental health and substance disorder benefits.

COMPLIANCE WITH HIPAA PRIVACY REQUIREMENTS

This Plan provides each Plan Participant with a separate Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act and the Health Information Technology for Economic and Clinical Health (HITECH) Act. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by contacting the HIPAA Compliance Officer(s).

HIPAA Privacy Officer(s): Deena Fisher, 952-896-1278

MICHELLE'S LAW NOTICE

Under a Federal law known as "Michelle's Law," the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of: (a) the date that is one 2023 after the first day of the medically necessary leave of absence or (b) the date on which the dependent's coverage would otherwise end under the Plan's terms. The dependent must provide written certification from the dependent's treating physician to the Plan.

Qualified Medical Child Support Orders (QMCSOs)

Please contact 952-896-9104 to obtain, without charge, a copy of the written procedures used by HealthEZ to determine the status of QMCSOs.

NO SURPRISES ACT

The No Surprises Act of the 2021 Consolidated Appropriations Act prohibits "surprise billing" or "balance billing" for emergency care at an out-of-network hospital, post-stabilization services provided in a hospital following an emergency visit or care received from an out-of-network Provider while at an in-network hospital or certain other facilities. The Plan must cover emergency services without requiring prior authorization and must cover emergency services even if the services are provided by Providers who are outside of the Plan's network. Any required cost sharing (co-pays, coinsurance, or deductibles) for emergency care received from an out-of-network Provider or facility must be the same as the cost sharing for emergency care received from a Provider or facility in the group health plan's network.