

**ANTIOCH UNIVERSITY
EMPLOYEE GROUP BENEFIT PLAN -
SUPPLEMENTAL PLAN**

REVISED EFFECTIVE JANUARY 1, 2011

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE COMPANY AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

MEDICAL BENEFITS ADMINISTRATORS, INC.

Established in 1989, Medical Benefits Administrators, Inc. (MBA) is a subsidiary of Medical Benefits Mutual Life Insurance Co., one of the oldest health insurance firms in the United States. In 1938, the Company entered the insurance business operating under the name Hospital Services Association. Later, it became known as HSA of Ohio.

The name, Medical Benefits Mutual, was adopted in 1987, signaling the Company's establishment as a full-fledged mutual life insurance company. Medical Benefits Administrators, Inc. builds on this great service tradition and commitment to the future by delivering the services the marketplace demands.

MBA is pleased to have been chosen as your Benefit Manager. MBA is committed to the fundamental criteria which distinguish us from the crowd. The first is a commitment to excellent claims administration. The second is a commitment to long term relationships with the people we serve.

We will appreciate your comments and strive to make any dealings with us as simple as possible. If you have any questions about a claim, we invite you to call us at (800) 423-3151, e-mail us at medben@medben.com or to drop in at our offices at 1975 Tamarack Road, Newark, Ohio 43055.

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ARTICLE I
PLAN INFORMATION

NAME OF PLAN

The name of the Plan is the Antioch University Employee Group Benefit Plan. The provisions described in this document apply to the Supplemental Plan.

PURPOSE OF THE PLAN

Antioch University executes this document, including any amendments, to establish a health benefit plan for the exclusive benefit of its participating employees and their eligible Dependents, and to grant them legally enforceable rights under this Plan. While Antioch University has every intention of continuing this Plan indefinitely, it reserves the right to amend or terminate the Plan, and the benefits provided hereunder, at any time.

The Plan Administrator has issued a Summary Plan Description to each Participant which summarizes the benefits to which that person is entitled, to whom benefits are payable, and the provisions of this Plan principally affecting the Participant and his or her covered Dependents.

PLAN EFFECTIVE DATE

The Plan Effective Date of this revision of the Plan is January 1, 2011. This Plan was originally effective on October 15, 1978.

AMENDMENT OR TERMINATION

Antioch University may amend or terminate the Plan at any time by means of a writing signed by a person authorized by Antioch University to do so. Any such amendment or termination shall become effective upon its execution or on such date as may be specified in that writing. Such amendment, modification or termination may result in the termination of Participant and Dependent coverage under the Plan. Expenses incurred prior to any Plan termination will be paid as provided under the terms of the Plan prior to such termination. Any termination of the Plan will be communicated by Antioch University to the Participants.

Upon Plan termination, any Plan assets remaining in the Plan's account(s) will be distributed by the Plan Administrator to the Plan Sponsor and/or Participants, in accordance with method(s) set forth in ERISA, or any other applicable law or regulation. The Plan Administrator shall pay all eligible Plan benefits and expenses before any distribution is made.

The terms of the Plan cannot be amended or modified by oral statement(s). Only the Plan Administrator can interpret the terms of the Plan.

Antioch University reserves the right, at any time and from time to time, to modify or amend, in whole or in part, any or all of the provisions of the Plan.

PLAN ADMINISTRATOR TAX ID NUMBER (EIN)

31-0536640

PLAN ADMINISTRATOR

Antioch University
150 East South College Street
Yellow Springs, Ohio 45387-1635
(937) 769-1375

PLAN NUMBER

505

GROUP NUMBER

10225

PLAN YEAR

The Plan Year is a time period defined for fiscal purposes and used for certain Plan reporting and disclosure requirements. The Plan Year will begin on July 1st and end on June 30th of the following year.

CALENDAR YEAR

The Calendar Year is the period beginning January 1st and ending December 31st which is used in the application of deductible, coinsurance and benefit maximum amounts.

TYPE OF ADMINISTRATION

Contract Administration.

DESCRIPTION OF PLAN

The Plan is an employee health and welfare benefit plan providing dental and vision benefits. A copy of the Plan documents and insurance contracts, if any, are on file at the Plan Administrator's office and may be read by any Covered Person at any reasonable time. In the event of any discrepancy between any summary of this Plan and the actual provisions of the Plan document, the Plan document shall govern.

The Plan shall not be deemed to constitute a contract between the Company and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any employee at any time.

NAMED FIDUCIARY

Antioch University
150 East South College Street
Yellow Springs, Ohio 45387-1635
(937) 769-1375

AGENT FOR SERVICE OF LEGAL PROCESS

Antioch University
150 East South College Street
Yellow Springs, Ohio 45387-1635
(937) 769-1375

In addition, service of legal process may be made upon the Plan Administrator or a Plan Trustee, if a Trustee has been appointed.

FUNDING

The Plan is funded by the Employer. Funds for payment of claims considered under the Plan are forwarded to account(s) from which claims are to be paid.

ASSIGNMENT

A Covered Person's benefits may not be assigned, except by consent of the Company, other than to providers of Plan benefits.

SOURCE OF CONTRIBUTIONS

The Plan is funded by contributions made by the Employer.

The Company shall, from time to time, evaluate the funding method of the Plan benefits and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by the Participants for each type of coverage.

COLLECTIVE BARGAINING AGREEMENTS

The Plan is established by the Company, Antioch University, and is subject to collective bargaining agreements between the Company and the United Electrical, Radio and Machine Workers of America (UEW), Local 796. A complete list of the Employer(s) and employee organization(s) sponsoring the Plan may be obtained by any Covered Person upon written request and is available for examination by Covered Persons at the Plan Administrator’s office.

The Plan is maintained pursuant to a collective bargaining agreement. Copies of the collective bargaining agreements are on file at the Plan Administrator’s office and may be read by any Covered Person at any reasonable time.

BENEFIT MANAGER

Medical Benefits Administrators, Inc.
1975 Tamarack Road
P. O. Box 1099
Newark, Ohio 43058-1099
(740) 522-8425
(800) 423-3151
www.medben.com

**ARTICLE II
SCHEDULE OF BENEFITS**

2.1 SCHEDULE OF DENTAL BENEFITS

This Schedule of Dental Benefits is intended to provide only a general description of a Covered Person’s dental benefits under this Plan. This Plan contains limitations and restrictions which are described later in the Plan document and could affect any benefits which may be payable.

2.2 DENTAL DEDUCTIBLE

Per Individual \$50.00

The Dental Deductible applies to Class II, Class III and Class IV expenses only.

2.3 DENTAL COINSURANCE AMOUNTS

	<u>Deductible</u>	<u>Coinsurance</u>
Class I (Preventive and Diagnostic)	None	100%
Class II (Basic)	Applies	90%
Class III (Major)	Applies	60%
Class IV (Orthodontic)	Applies	50%

Please see additional limitations in the schedule of Dental Plan Maximum Benefits set forth in Section 2.4 of the Plan.

2.4 DENTAL PLAN MAXIMUM BENEFITS

The dental plan maximum benefits and limitations are shown below. Both Calendar Year and lifetime maximums indicate the actual benefits payable under the Plan.

Periodontal Procedures	\$1,000.00 per Lifetime maximum
Class I, Class II and Class III, combined	\$1,500.00 per Calendar Year maximum
Class IV	\$1,000.00 per Lifetime maximum Covered for Dependent children up to the age of nineteen (19) only

2.5 PREDETERMINATION OF BENEFITS

Before starting a course of treatment for which the charge is expected to be \$600.00 or more, a dental treatment plan should be submitted in an acceptable form to the Benefit Manager. A Predetermination of Benefits payable under this Plan will then be provided.

For more information about Predetermination of Benefits, see Section 7.3.

2.6 SCHEDULE OF VISION BENEFITS

This Schedule of Vision Benefits is intended to provide only a general description of a Participants vision benefits under this Plan. This Plan contains limitations and restrictions which are described later in the Plan document and could affect any benefits which may be payable.

Deductible	None
Coinsurance	100%

Service/Supply	Calendar Year Maximum	Frequency Limitation
Examination	Reasonable & Customary charge for examination	One per Calendar Year
Lenses, Frames & Contact Lenses, Combined	\$100.00 per Calendar Year	None

ARTICLE III
DEFINITIONS

All terms which are defined in this Article III are capitalized wherever they appear in this Plan.

3.1 GENERAL PLAN DEFINITIONS

ACCIDENT

The term "Accident" means an event arising from extrinsic causes, which is sudden, unforeseen and unintended.

ACTIVELY AT WORK OR ACTIVE WORK

The terms "Actively at Work" or "Active Work" mean the active expenditure of time and energy in the service of the Company. A Participant shall be deemed Actively at Work while working the full number of hours shown in Section 5.2 and while in a relationship with the Employer within the meaning of "employee" for federal tax withholding purposes. In addition, individuals acting as independent contractors; leased employees; consultants; a member of the Board of Directors; temporary, free lance, incidental, seasonal or occasional employees; individuals on retainers; or retirees are not considered Actively At Work unless each meets the requirements specified in Section 5.2.

BENEFIT MANAGER

The term "Benefit Manager" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Benefit Manager is appointed or retained (as a result of the termination or expiration of such agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Manager in writing, the term will mean the Plan Administrator.

As of the Effective Date, the Benefit Manager of the Plan is Medical Benefits Administrators, Inc.

CALENDAR YEAR

The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. Midnight, through the next December 31st.

CLOSE RELATIVE

The term "Close Relative" means the Covered Person's spouse, domestic partner, child, grandchild, brother, sister, parent or grandparent, whether by birth, adoption, marriage or domestic partnership.

COBRA

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

COMPANY

The term "Company" means Antioch University, the Plan sponsor.

COVERED EXPENSES

The term "Covered Expenses" means expenses incurred by a Covered Person for any Medically Necessary treatments, services or supplies that are not specifically excluded from coverage elsewhere in this Plan.

COVERED PERSON

The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

DEPENDENT

The term "Dependent" means:

- A. the Participant's legal spouse. Such marriage must have met all requirements of a valid marriage contract in the state in which such parties were married;
- B. the Participant's domestic partner. In order for such person to be considered an eligible Dependent, the Participant and the domestic partner must meet the following requirements and must certify that they:
 - 1. share the same residence and have done so for at least the six (6) month period immediately prior to enrolling the person for coverage as a domestic partner under this Plan;
 - 2. have a close personal relationship with the intent for the relationship to continue;
 - 3. are jointly responsible for basic living expenses, including the cost of basic food, shelter and other living expenses;
 - 4. are not legally married to any other individual;
 - 5. are eighteen (18) years of age or older;
 - 6. are not related by blood closer than would bar legal marriage;
 - 7. were mentally competent to consent to contract when the domestic partner relationship began; and
 - 8. are each other's sole domestic partner and are responsible for each other's welfare; or
- C. the Participant's child who meets all of the following conditions:
 - 1. is unmarried;
 - 2. is not employed on a regular and full-time basis;
 - 3. is one of the following:
 - a. the Participant's natural child, adopted child, or is a child Placed For Adoption with the Participant;
 - b. the Participant's stepchild, child of the Participant's domestic partner, an agency placed foster child or a child who is under the Participant's Legal Guardianship, provided that any such child resides with the Participant on a permanent basis for at least six (6) months per year in a regular parent-child relationship; or
 - c. any child that the Plan Administrator determines is eligible for coverage under the terms of a Qualified Medical Child Support Order;
 - 4. is dependent upon the Participant for at least fifty percent (50%) of his or her support. This requirement is waived if the Participant is obligated to provide Medical Care coverage for a natural or adopted child, or a child who has been Placed for Adoption with the Participant under an order or judgment of a court of competent jurisdiction; and
 - 5. is less than twenty-five (25) years of age. The age requirement above is waived for any unmarried mentally or physically handicapped child who is incapable of supporting his or her self financially and is dependent upon the Participant for support, provided the child suffered such incapacity prior to attaining twenty-five (25) years of age. Proof of incapacity must be furnished to the Plan Administrator, or its designee, within thirty-one (31) days of the date the child's coverage would have ended due to age.

The Plan Administrator has the right to obtain sufficient proof of Dependent status from any Participant under the Plan who is requesting coverage of his or her Dependents.

This definition and all provisions of this Plan are intended to comply with state and federal law as both regard "Qualified Medical Child Support Orders" and "Medical Child Support Orders," as those terms are defined in the law. The Plan Administrator has established procedures governing "Qualified Medical Child Support Orders". Covered Persons under this Plan can receive upon request, free of charge, a copy of such procedures from the Plan Administrator.

The term "Dependent" excludes these situations:

- A. a spouse who is legally separated or divorced from the Participant. Such spouse must have met all the requirements of a valid separation or divorce in the state granting such separation or divorce; or
- B. any person who is covered under this Plan as an individual Participant, or as a Dependent of any other Plan Participant.

DEPENDENT COVERAGE

The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent.

EMPLOYER

The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Internal Revenue Code of 1986, as amended, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the Company. An employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

ERISA

The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

FAMILY

The term "Family" means a covered Participant and his or her covered Dependents.

HEALTH INFORMATION

The term "Health Information" means any information, whether oral or recorded in any form or medium that:

- A. is created or received by this Plan, or a Plan designee; and
- B. relates to any of the following:
 - 1. the past, present or future physical or mental health or condition of an individual;
 - 2. the provision of health care to an individual; or
 - 3. the past, present or future payment for the provision of health care to an individual.

INJURY

The term "Injury" means bodily damages caused solely and exclusively, directly and independently of all other contributing causes, by an Accident.

LEGAL GUARDIAN OR LEGAL GUARDIANSHIP

The terms "Legal Guardian" or "Legal Guardianship" mean a person, or the status of a person and his or her ward, who has been appointed by a state court with specific jurisdiction over guardianships and estates, to have the care and management of a minor child. The Legal Guardian must have guardianship of the person of the minor child, and not merely the estate of such child. An order granting a person legal custody of a minor child, without the appointment of the person as the child's Legal Guardian, does not create a Legal Guardianship.

LIFETIME

The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime" means the total time period of a Covered Person's coverage

under this Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term “Lifetime” mean the duration of a Covered Person’s life.

NAMED FIDUCIARY

The term "Named Fiduciary" means the individual or entity which has the ultimate authority to control and manage the overall operation of the Plan.

NEWBORN

The term "Newborn" means an infant from the date of birth through the time the mother is also confined in the Hospital following birth, or during the first five (5) days following the birth, whichever is shorter.

PARTICIPANT

The term "Participant" means a person who meets the eligibility requirements listed in Section 5.2 and who is properly enrolled in the Plan.

PARTICIPANT CONTRIBUTION

The term "Participant Contribution" means that amount which is due from an eligible employee in order for that employee to obtain Participant and/or Dependent coverage(s) under the Plan. The Company shall determine the amount of the Participant Contribution which may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

PLACED FOR ADOPTION OR PLACEMENT FOR ADOPTION

The terms "Placed For Adoption" or "Placement For Adoption" mean the assumption and retention by such Participant hereunder of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with such Participant terminates upon the termination of such legal obligation.

PLAN

The term "Plan" means the sickness and Accident plan, as described in and administered by the Antioch University Employee Group Benefit Plan. The provisions of this document shall apply to the Supplemental Plan.

PLAN ADMINISTRATOR

The term “Plan Administrator” means the entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. Antioch University is the Plan Administrator as of the Plan Effective Date.

PLAN YEAR

The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on July 1st and end on June 30th of the following year.

PLAN EFFECTIVE DATE

The Plan Effective Date of this revision of the Plan is January 1, 2011. This Plan was originally effective on October 15, 1978.

PROTECTED HEALTH INFORMATION

The term “Protected Health Information” means Health Information that either identifies an individual, or for which there is a reasonable basis to believe can be used to identify an individual and which is one (1) of the following:

- A. transmitted by electronic media, including:
 - 1. the internet;
 - 2. an extranet;
 - 3. leased lines;
 - 4. dial-up lines;
 - 5. private networks; and
 - 6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media;
- B. maintained in any electronic media; or
- C. transmitted or maintained in any other form or medium.

REASONABLE AND CUSTOMARY

The term "Reasonable and Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services and supplies, medication or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise.

SERVICE IN THE UNIFORMED SERVICES

The term “Service in the Uniformed Services” means performance of duty in the Armed Forces or Uniformed Services for a period of five years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

SUMMARY HEALTH INFORMATION

The term “Summary Health Information” means information that may be individually identifiable Health Information that:

- A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and
- B. from which the following information has been removed:
 - 1. names;
 - 2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
 - 3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge;
 - 4. telephone numbers;
 - 5. fax numbers;
 - 6. electronic mail addresses;

7. social security numbers;
8. medical record numbers;
9. Plan identification numbers; or
10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

3.2 DENTAL PLAN DEFINITIONS

COURSE OF TREATMENT

The term “Course of Treatment” means a plan of one (1) or more services or supplies by one (1) or more Dental Practitioners for the treatment of a dental condition. The condition must have been diagnosed by the Dental Practitioner as the result of an oral examination. The Course of Treatment starts on the date the practitioner first renders a service to correct or treat the condition.

COVERED DENTAL EXPENSES

The term “Covered Dental Expenses” means the charges for the procedures listed as covered in Article XI.

DEDUCTIBLE

The term "Deductible" means the amount of dental Covered Expenses incurred by a Covered Person in a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Schedule of Benefits and this Plan.

An Individual Deductible is the amount that each individual Covered Person must pay during a Calendar Year before the Plan begins paying benefits for that person.

DENTAL PRACTITIONER

The term “Dental Practitioner” means a dentist, Dental Hygienist or a denturist.

ORTHODONTIC TREATMENT

The term “Orthodontic Treatment” means the movement of teeth through bone. This treatment uses orthodontic Appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Treatment is not covered under this Plan.

TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION OR DISORDER

The term “Temporomandibular Joint (TMJ) Dysfunction or Disorder” means temporomandibular joint and craniomandibular disorders, or other conditions of the joint linking the jaw bone and the skull and the complex of muscles, nerves and other tissues related to that joint, by whatever name the condition is called.

TREATMENT PLAN

The term “Treatment Plan” means the Dental Practitioner’s report which:

- A. lists the dental care recommended;
- B. shows the Dental Practitioner’s fees for each Dental Procedure; and
- C. includes x-rays taken before treatment and other necessary data related to the treatment needed.

3.3 COMMON DENTAL TERMS

ABUTMENT

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

ACID ETCH

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

ACRYLIC

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

AMALGAM

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

ANESTHESIA

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

ANTERIOR TEETH

The central incisors, lateral incisors and cuspids.

APPLIANCE

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

BITEWING

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

BRIDGEWORK, BRIDGE OR PROSTHETIC APPLIANCE

Fixed - Pontics or replacement teeth retained with crowns or inlays cemented to the natural teeth, which are used as abutments. **Fixed, Removable** - One that the dentist can remove but the patient cannot. **Removable** - A partial denture retained by attachments which permit removal of the denture. Normally held by clasps.

CARIES

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

COMPOSITE

Tooth colored filling material primarily used in the anterior teeth.

CROWN

A natural crown is the portion of a tooth covered by enamel. An artificial crown (cap) restores the anatomy, function and esthetics of the natural crown.

DENTAL HYGIENIST

A person who has been trained to clean teeth, and provide additional services and information on the prevention of oral disease.

DENTURE

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

ENDODONTIC THERAPY

Treatment of diseases of the dental pulp and their sequelae.

FLUORIDE

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

IMPLANT

A device surgically inserted into or onto the jawbone. It may support a crown or crowns, partial denture, complete denture or may be used as an abutment for a fixed bridge.

IMPRESSION

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

INLAY

A restoration usually of cast metal made to fit a prepared tooth cavity and then cemented into place.

MALOCCLUSION

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

OCCLUSION

The contact relationship of the upper and lower teeth when they are brought together.

ONLAY

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

PALLIATIVE

An alleviating measure. To relieve, but not cure.

PARTIAL DENTURE

A prosthesis replacing one or more, but less than all, of the natural teeth and associated structures; may be removable or fixed, one side or two sides.

PEDODONTICS

The specialty of children's dentistry.

PERIODONTICS

The science of examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth.

PONTIC

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

POSTERIOR TEETH

The bicuspid and molars.

PROPHYLAXIS

The removal of tarter and stains from the teeth. The cleaning of the teeth by a dentist or Dental Hygienist.

REBASE

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

RELINE

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

RESTORATION

A broad term applied to any Inlay, Crown, Bridge, Partial Dentures, or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end

result of repairing and restoring or reforming the shape, form and function of part or all of a tooth or teeth.

ROOT CANAL THERAPY

The complete removal of the pulp tissues of a tooth, sterilization of the pulp chamber and root canals, and filling these spaces with a sealing material.

SCALING

The removal of calculus (tarter) and stains from teeth with special instruments.

SEALANT

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

SILICATE

A relatively hard and translucent restorative material that is used primarily in the anterior teeth.

SPLINTING

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

TOPICAL APPLICATION

Painting the surface of teeth, as in Fluoride Treatment or application of an anesthetic formula to the surface of the gum.

VERTICAL DIMENSION

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

ARTICLE IV CLAIMS AND APPEALS PROCEDURES

4.1 INITIAL FILING OF CLAIMS

A claim for benefits should be filed within ninety (90) days after the occurrence or commencement of any loss covered by this Plan. Failure to give such notice and proof within the time required will neither invalidate nor reduce any claim if it is shown that written notice and proof are given no later than one (1) year after the claim is incurred], unless the Covered Person is legally incapacitated.

Upon termination of the Plan, final claims must be received within ninety (90) days of termination. In any of the events described above, notice and proof of claim will be determined at the discretion of the Plan Administrator, subject to the requirements listed below.

Claims should be submitted to the appropriate address listed on the Covered Person's identification card, and can be submitted either by the provider or the Covered Person. Such claim should be on any of the following appropriate forms (or their successor forms):

- A. CMS 1500;
- B. UB-04 or UB-92;
- C. HCFA-1450 or CMS 1450;
- D. NCPDP Form 1983; or
- E. J512 claim forms.

A claim can be submitted by the provider in electronic format if the provider submits it in accordance with the electronic transaction requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent laws.

Such claims must use the most current CPT code in effect as published by the American Medical Association, the most current ICD-9 code in effect as published by the US Department of Health and Human Services, the most current dental code in effect as published by the American Dental Association in the *Code for Dental Procedures or Nomenclature* or the most current HCPCS code in effect, as published by US Department of Health and Human Services, Centers for Medicare and Medicaid Services.

If the Plan is not the primary carrier for a Covered Person who has, or had at the time the claim was incurred, more than one health plan that would provide benefits for the services or supplies for which the claim is being made, including, but not limited to Medicare, copies of the explanations of benefit payment from all carriers who would pay benefits before the Plan should be submitted with the claim. For more information regarding which plan pays first, see Section 12.1, or contact the Benefit Manager.

4.2 REQUESTS FOR ADDITIONAL INFORMATION

If the claim is not submitted in accordance with the procedures listed in Section 4.1, the Participant or Covered Person will be notified of the claim deficiencies, and requested to refile it in the proper format.

If the Plan Administrator or the Benefit Manager needs more information to process the claim, a letter will be sent to the Participant, the Covered Person, the provider or other parties requesting additional information. In some situations, information is needed on a periodic basis, including:

- A. information regarding other coverage. This may include providing copies of medical child support orders for children of divorced parents;
- B. verification of full-time student status for Dependent children when the Plan requires such status to maintain eligibility; and

C. verification of handicapped status for overage Dependent children.

Other information may be requested on a case-by-case basis, including information pertaining to accident details or potential third-party liability.

The requested information must be provided within forty-five (45) days of the date the Participant or Covered Person receives notice of the required additional information. If the information is not received within this time period, the claim will be denied for failure to provided the needed information.

4.3 APPEALS OF ADVERSE BENEFIT DETERMINATIONS

The Covered Person can appeal a decision by the Plan that coverage for a service or supply is denied or reduced under the Plan, including pre-service coverage denials, provided such appeal is made in writing within one hundred eighty (180) days of the Covered Person or Participant's receipt of the explanation of benefit payment or the precertification letter reflecting the denial or reduction. Any individual other than the Covered Person who wishes to submit an appeal on the Covered Person's behalf (other than a parent or Legal Guardian filing an appeal for a minor child) must be designated by the Covered Person, in a writing signed by the Covered Person, as his or her authorized representative specifically for the purpose of the appeal. An assignment of benefits is not sufficient to designate another person as an "authorized representative" for the purpose of an appeal. These appeal procedures shall not apply to any contractual dispute between a provider and the Plan as to amounts due the provider, rather than the Covered Person, under the terms of any agreement between the provider and the Plan that does not affect the amount payable by the Covered Person (i.e. balance billing issues in a Preferred Provider contract).

The appeal request should be addressed as follows (unless the adverse benefit determination notification indicates otherwise):

Plan Administrator
Antioch University Employee Group Benefit Plan – Supplemental Plan
c/o Benefit Manager
Medical Benefits Administrators, Inc.
P.O. Box 1099
Newark, Ohio 43058-1099

The writing should clearly be identified as an appeal, and include the name of the Plan, the Covered Person whose claims are the subject of the appeal, the Participant's identification number, and the identity of the specific treatment, service or supply for which coverage was denied or limited under the Plan.

The Covered Person should submit with the appeal written comments, documents, records and other information relating to the claim for benefits, even if such information was not submitted as part of the initial claim or request for preauthorization or precertification.

The Covered Person has the right to request information from the Plan Administrator as part of the appeals process, as described in Section 4.5.

The Plan Administrator has the sole authority for the final decision on all Plan matters, including appeals.

4.4 ACCESS TO DOCUMENTS, RECORDS OR OTHER INFORMATION

A Covered Person is entitled to receive, upon request and free of charge, reasonable access to documents, records and other information relevant to his or her claim for benefits. Such information is considered to be relevant if it:

- A. was relied upon by the Plan Administrator in making the benefit determination;
- B. was submitted, considered or generated in the course of making the benefit determination;
- C. demonstrates compliance with the administrative processes required by ERISA;

- D. constitutes a statement of policy or guidance with respect to the Plan concerning the denial of a treatment option or benefit; or
- E. involves the identity of medical or vocational experts whose advice was obtained in connection with the claim.

In addition, if an adverse benefit determination is based upon the Medical Necessity or Experimental nature of the service or supply, the Covered Person can request an explanation of the scientific or clinical judgment of the determination, free of charge.

4.5 ADDITIONAL APPEAL RIGHTS

If, after the Covered Person has exhausted all appeal and review rights listed above, he or she is still not satisfied with the disposition of the claim, such Covered Person has the right to bring an action under section 502(a) of the Employee Retirement Income Security Act (ERISA).

No action at law or in equity shall be brought to recover benefits under the Plan prior to the exhaustion of all claims and appeals procedures described in this Article, nor shall such action be brought at all unless brought within three (3) years from the expiration of the time within which proof is required by the Plan.

4.6 EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose injury or illness is the basis of a claim hereunder when and as often as it may reasonably require during the pending claim. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death, where it is not forbidden by law.

4.7 PLAN ADMINISTRATOR DISCRETION

Nothing in this Plan precludes the Plan Administrator from exercising full discretionary authority and responsibility with respect to all aspects of Plan administration and interpretation. The Plan Administrator shall have all powers necessary to carry out the purposes of the Plan, including supplying any omissions in accordance with the intent of the Plan and deciding all questions concerning eligibility for participation in the Plan and concerning the amount of benefits payable to a Covered Person.

ARTICLE V
COVERAGE AND ELIGIBILITY

5.1 COVERAGE UNDER THIS PLAN

Coverage provided under the Plan for a Participant shall be in accordance with the Participant Eligibility, Participant Effective Date and Participant Termination provisions included herein.

5.2 PARTICIPANT ELIGIBILITY

Only employees who meet all of the following conditions shall be deemed eligible for coverage as a Participant under the Plan:

- A. is employed by the Employer on a regular, full-time basis for at least eighteen (18) hours per week for at least nine (9) months of the year; and
- B. is not eligible for coverage as a Participant or Dependent under any other health plan option providing similar benefits which is sponsored by the Employer.

Participants must agree to any applicable Participant Contribution for such coverage.

5.3 DEPENDENT COVERAGES

A Participant eligible to elect Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent, set forth in Article III of the Plan. A Participant must make written request for Dependent Coverage and agree to any applicable Participant Contribution for such coverage. Each Participant will become eligible to elect Dependent Coverage on the latest of the following:

- A. the date he becomes eligible for Participant coverage; or
- B. the date on which he first acquires a Dependent.

If both the husband and wife are eligible for coverage through a plan sponsored by the Employer, and both are eligible to elect Dependent coverage, either the husband or wife, but not both, may elect Dependent Coverage for the eligible Dependents. In addition, no individual can be covered under this Plan (or any other Employer Plan providing similar benefits) as the Dependent of more than one (1) Participant.

5.4 PARTICIPANT EFFECTIVE DATE

Each eligible employee who makes written request for Participant coverage hereunder, on a form approved by the Plan Administrator, subject to the provisions of this section, and who agrees to the applicable Participant Contribution for such coverage, shall become effective on the following date, provided the written application for such coverage is made within thirty-one (31) days of the date he or she becomes eligible for Participant Coverage:

- A. if first employed on the 1st through the 14th of any month, on the first day of the month following the date of hire; or
- B. if first employed on the 15th of the month through the end of the month, on the first of the second month following his or her date of hire

Any eligible person who wishes to make an application for Participant coverage other than as described above, or as described in Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8 before such application can be submitted.

5.5 DEPENDENT EFFECTIVE DATE

Each Participant who makes written request for Dependent Coverage hereunder within the thirty-one (31) day period immediately following the first day on which he or she is eligible for Dependent Coverage, on a form approved by the Plan Administrator, subject to the provisions of this section, and who agrees to the applicable Participant Contribution for such coverage,

shall become eligible for Dependent Coverage on the later of the date he or she is eligible for Dependent Coverage or the date the Participant becomes covered.

Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8 before such application can be submitted.

5.6 NEWBORN CHILDREN

If the Participant already has Dependent Coverage in effect as of the date of birth, the Participant's Newborn will be automatically covered. If the Participant does not have Dependent Coverage in effect as of the date of birth, application must be made for the Newborn within thirty-one (31) days after the birth. In either case, coverage will be effective on the date of birth. Any Participant who wishes to make an application for Dependent Coverage other than as described above, or as described in Section 5.7, shall be required to wait until the next Plan open enrollment period, as described in Section 5.8 before such application can be submitted.

5.7 SPECIAL ENROLLMENT PERIODS

An eligible person for whom written application for coverage is submitted under any of the circumstances listed below will be eligible for coverage on the date specified below:

- A. within thirty-one (31) days of the date of a Dependent child's birth. The eligible employee, the Newborn, the Dependent spouse, and any other eligible Dependents are entitled to this special enrollment period. Coverage shall become effective on the date of the Dependent child's birth;
- B. within thirty-one (31) days after the adoption of a Dependent child, or the Placement for Adoption with the employee of such a child. The eligible employee, the newly acquired Dependent child, the Dependent spouse, and any other eligible Dependents are entitled to this special enrollment period. Coverage shall become effective on the date of the adoption or Placement for Adoption;
- C. within thirty-one (31) days of the date of the eligible employee's marriage. The eligible employee, the new Dependent spouse, and any other eligible Dependent children are entitled to this special enrollment period. Coverage shall become effective on the first of the month following the date of the marriage;
- D. within thirty-one (31) days of the entry of an order requiring the employee to provide similar coverage for a Dependent child. The eligible employee, the Dependent child or children who are the subject of the court order, the Dependent spouse, and any other eligible Dependents are entitled to this special enrollment period. Coverage shall become effective on the first of the month following the date of the court order;
- E. within thirty-one (31) days of the date the employee or an eligible Dependent loses similar coverage under another group health plan or health insurance coverage was lost, if:
 1. the reason the eligible employee and/or Dependent did not enroll for coverage under this Plan when initially eligible was the existence of the other coverage; and
 2. the person lost coverage under the other plan due to one (1) of the following:
 - a. if covered under a COBRA continuation provision, the exhaustion of COBRA continuation coverage under the other plan;
 - b. the loss of eligibility for coverage due to legal separation, divorce, death, termination of employment, reduction in hours of employment or other involuntary loss of eligibility (with the exception of terminations due to fraud or failure to pay premiums); or
 - c. the termination of employer contributions towards such other coverage.

Coverage for which a person is eligible under this provision shall become effective on the first of the month following the date coverage under the prior plan is terminated. All then eligible Family members are entitled to this special enrollment period; or

- F. within sixty (60) days of the date an eligible employee and/or his or her Dependent(s) first become eligible for coverage under a state Medicaid or Children's Health Insurance Program (CHIP), or, if covered, becomes ineligible for coverage through such programs. The eligible employee and any eligible Family member who becomes eligible or loses eligibility through such programs are eligible to enroll during this special enrollment period. Coverage shall become effective on the first of the month following the date of eligibility/ineligibility.

In no event shall any person become covered under this Plan prior to the date the Participant becomes a Covered Person, or prior to the end of the waiting period listed in Section 5.2.

5.8 OPEN ENROLLMENT

The Plan will have an annual open enrollment period during which otherwise eligible persons who were not enrolled when initially eligible (or who previously terminated coverage) and do not qualify for one of the special enrollment periods described in Section 5.7 can be enrolled in the Plan. A Participant may also voluntarily terminate any coverage during this open enrollment period. The open enrollment period will be held some time during the end of the Calendar Year. The specific dates of the application period for any year will be announced in advance by the Plan Administrator. Coverage for any person for whom application for coverage under this Plan was submitted pursuant to this provision, or any requested termination, shall be effective January 1st of the Calendar Year following the year in which the open enrollment was conducted.

5.9 PARTICIPANT TERMINATION

Participant coverage terminates immediately only upon the earliest of the following dates:

- A. the last day of the month in which the Participant no longer meets the eligibility requirements listed in Section 5.2;
- B. December 31st of any Calendar Year in which the Participant voluntarily terminates coverage during an open enrollment period;
- C. the date that the Participant becomes covered as a Participant or Dependent under any other health plan providing similar benefits which is sponsored by the Employer;
- D. the last day of the period for which a Participant Contribution was made following the date the Participant fails to make any required Participant Contribution for coverage; or
- E. the date the Plan is terminated or, with respect to any benefit of the Plan, the date of termination of any such benefit.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the Family and Medical Leave provisions as described in Section 0, and COBRA continuation coverage as described in Article VII. This Plan will also comply with the continuation provisions contained in the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) as they apply to Participants entering Service in the Uniformed Services.

5.10 DEPENDENT TERMINATION

Dependent Coverage terminates immediately only upon the earliest of the following dates:

- A. the date the Participant's coverage ceases under this Plan, unless such Dependent qualifies for continuation as described in Section 5.11;
- B. the date the Dependent ceases to be a Dependent, as defined in the Plan;

- C. the date that the Dependent becomes covered as a Participant under this Plan or a Participant or Dependent under any other health plan providing similar benefits which is sponsored by the Employer;
- D. December 31st of any Calendar Year in which the Participant voluntarily terminates coverage for such Dependent(s) during an open enrollment period;
- E. the last day of the period for which a Participant Contribution for Dependent Coverage was made following the date the Participant fails to make any required Participant Contribution for Dependent Coverage; or
- F. the date of cancellation of Dependent benefits under this Plan.

In addition, coverage may continue under the Plan, under certain circumstances and in accordance with applicable federal laws. Such continuation may be at the Participant's or Dependent's own expense. For further clarification, refer to the COBRA continuation coverage as described in Article VII.

5.11 CONTINUATION OF COVERAGE FOR SURVIVING DEPENDENTS

If the Participant is covered under this Plan as an active, full-time employee (not COBRA) on the date of his or her death, coverages then in force for his or her enrolled Dependents will continue until the earliest of the following dates:

- A. the date any required Participant Contribution for this coverage is not made;
- B. the date the Plan is amended to eliminate this continuation provision;
- C. the date the surviving spouse remarries;
- D. the date the person no longer meets the definition of a Dependent under this Plan;
- E. the date that is one (1) year from the date of the Participant's death; or
- F. the date that this Plan is terminated.

Any continuation rights that the Dependent may be entitled to under the provisions of COBRA, as described in Article VII, shall begin after the period of continuation described above.

5.12 CONTINUATION OF COVERAGE

Coverage for a Participant and his or her eligible Dependents under this Plan may be continued if the Participant is no longer eligible for coverage because he or she is on an approved non-medical leave of absence/layoff until the earliest of the following dates:

- A. the end of a period of three (3) months following the month the leave began, the end of a period of twelve (12) months following the month the leave began, for Faculty and Administrative Employees.
However, if leave is taken intermittently or on a reduced leave schedule and qualifies as a leave under the Family and Medical Leave Act (FMLA), the three (3) month period will be extended, if necessary, to provide up to the equivalent of twelve (12) weeks of full leave during any twelve (12) month period.
- B. the date the Participant is required to return to Active Work by the Employer, and he or she fails to do so;
- C. the date the Participant fails to make any required Participant Contribution for this coverage; the date that this Plan is terminated.

5.13 REINSTATEMENT

If a Participant's coverage is terminated under this Plan because he or she no longer meets the eligibility requirements listed in Section 5.2, and such Participant once again meets such requirements within three (3) months of the date of termination, coverage for such Participant and his or her then eligible Dependents will be reinstated in this Plan effective the date he or

she once again meets such requirements, provided written application for coverage is submitted within thirty-one (31) days of such reeligibility.

5.14 FAMILY AND MEDICAL LEAVE PROVISIONS

This Plan intends to comply with the Family and Medical Leave Act of 1993 (FMLA) regarding the maintenance of health benefits during any period that an eligible employee takes a leave of absence in accordance with the Employer's FMLA policy, if the Employer is subject to such law. In applicable situations, FMLA allows an eligible employee to maintain group health plan coverage at the level and under the conditions coverage would have been provided if the employee had continued in employment continuously for the duration of such leave. Employee eligibility requirements, the obligations of the Employer and employees concerning conditions of leave, and notification and reporting requirements are specified in the Employer's FMLA policy. If the Employer is subject to FMLA, any Plan provision which conflicts with FMLA is superseded by FMLA to the extent such provision conflicts with FMLA. Questions regarding rights and/or obligations under FMLA should be directed to an Employer representative or the Plan Administrator.

5.15 USERRA RIGHTS

A Participant under this Plan who is no longer Actively At Work due to his or her Service in the Uniformed Services can elect, under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) to continue Participant and Dependent Coverage under this Plan for up to twenty-four (24) months after such coverage would otherwise have terminated. This period of continued coverage shall run concurrently with any continuation for which any Covered Person would have been entitled to under the provisions of COBRA due to the Participant's termination or reduction in hours of employment. If the Service in the Uniformed Services is for thirty-one (31) days or more, the Participant Contribution for such coverage will be one hundred two percent (102%) of the full cost of the coverage, without any Employer contribution. If the Service in the Uniformed Service is less than thirty-one (31) days, the Participant Contribution shall be the same as would have applied if the Participant were still an active employee.

If coverage is not continued as described above, or the Service in the Uniformed Services exceeds the time limit listed above, upon release from his or her Service in the Uniformed Services, coverage will be reinstated in the Plan effective the date the employee is reemployed by the Employer, provided the employees reapplies for employment or reports back to work within the following applicable time:

- A. if the period of service was less than thirty-one (31) days, the beginning of the next regularly scheduled work period on the first full day after release from Service in the Uniformed Services, taking into account safe travel home plus an eight (8) hour rest period;
- B. if the period of service was more than thirty (30) days, but less than one hundred eighty-one (181) days, within fourteen (14) days of release from Service in the Uniformed Services; and
- C. if the period of service was more than one hundred eighty (180) days, but less than five (5) years, within ninety (90) days of the release from Service in the Uniformed Services.

This period may be extended for up to two (2) years from the date the Service in the Uniformed Services ended, under the provisions of USERRA, if the person is unable to return to active employment due to a disability incurred while performing Service in the Uniformed Services.

The Plan Administrator reserves the right to request verification of any Service in the Uniformed Services, including copies of military orders or the applicable Form DD 214.

ARTICLE VI

CONTINUATION COVERAGE UNDER COBRA

6.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

- A. the date of the qualifying event; or
- B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, and his or her petition for certification for trade adjustment assistance (TAA) under the Trade Act of 1974 was submitted on or after November 4, 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss that qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible. The period of time between the original termination of coverage, and the coverage that is elected pursuant to this paragraph will not be regarded for purposes of determining whether the individual has experienced more than a sixty-two (62) day break in coverage under the Creditable Coverage provisions of this Plan.

6.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company, in writing addressed to the Plan Administrator, of the Qualifying Event within sixty (60) days of the event, or sixty (60) days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled "Total Disability" in order for coverage to continue.

6.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee may continue coverage under the Group Health Plan for:

- A. up to eighteen (18) months from the date of the Qualifying Event; or
- B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce or Medicare eligibility, and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event; or
- C. if a Qualified Beneficiary is Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to twenty-nine (29) months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Company of the determination of his or her Total Disability under the Social Security Act:

1. before the end of the original eighteen (18) month continuation period; and
2. within sixty (60) days following the date of such determination.

6.4 TERMINATION OF CONTINUATION OF COVERAGE

Continuation Coverage will automatically end earlier than the applicable 18 or 36-month period for a Qualified Beneficiary if:

- A. the required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;
- B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary;
- C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;
- D. the Qualified Beneficiary becomes entitled to Medicare benefits; or
- E. the Company ceases to offer any Group Health Plans.

6.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) months, and a second Qualifying Event occurs during the eighteen (18) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

6.6 TOTAL DISABILITY

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

- A. prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and
- B. within sixty (60) days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification. The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section.

If during the period of extended coverage for Total Disability (Continuation Coverage months 19-29) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

- A. the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and
- B. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

6.7 CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible and Copayment features for the year will be carried forward into the Continuation Coverage elected for that year.

Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

6.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, that will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

- A. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.
- B. For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months 19-29.
- C. Contributions for coverage may, at the election of the payer, be paid in monthly installments.
- D. If Continuation Coverage is elected, the first monthly contribution for coverage must be made within forty-five (45) days of the date of election.

Without further notice from the Company, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A.

No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

6.9 DEFINITIONS

For purposes of this Article VII, unless specifically stated otherwise, the following definitions apply:

- A. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- B. "Code" means the Internal Revenue Code of 1986, as amended.
- C. "Company" means the Employer, as defined in Article III.
- D. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.
- E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.
- F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.
- G. "Qualified Beneficiary" means:

1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and
 2. a covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.
- H. "Qualifying Event" means the following events that, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:
1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;
 2. the death of the Covered Employee;
 3. the divorce or legal separation of the Covered Employee from his or her spouse;
 4. the Covered Employee becoming entitled to Medicare coverage; or
 5. a child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.
- I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

6.10 COBRA BANKRUPTCY PROVISIONS UNDER TITLE XI

For purposes of this subsection only:

- A. "Qualified Beneficiary" means:
1. a Covered Employee who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Group Health Plan;
 2. an individual who was covered under the Group Health Plan as a surviving spouse of a deceased retiree on the day before the date of the Qualifying Event; and
 3. a Dependent of either of the above described individuals who was covered under the Group Health Plan on the day before the date of the Qualifying Event.
- B. "Qualifying Event" means the substantial elimination of coverage under the Group Health Plan within one (1) year before or after the Company files a petition in bankruptcy under Title XI of the United States Code.

If a Qualified Beneficiary experiences a Qualifying Event, as defined in this provision, he or she may elect to continue coverage under the Group Health Plan if he or she pays the monthly contribution specified from time to time by the Company and makes his or her election in accordance with the provision above entitled "Right to Elect Continuation Coverage."

Continuation Coverage for a Qualified Beneficiary who is a retiree and his or her Dependents who are Qualified Beneficiaries will continue for the life of the retiree. When the retiree dies, his or her Qualified Beneficiaries may elect to continue coverage for up to thirty-six (36) additional months.

If a surviving spouse and Dependent children are covered as beneficiaries of a deceased retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving spouse. Upon the death of the surviving spouse, the Continuation Coverage terminates.

Continuation Coverage elected under this provision will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Company ceases to offer any Group Health Plans.

ARTICLE VII

DESCRIPTION OF DENTAL BENEFITS

7.1 DENTAL BENEFITS – COVERED EXPENSES

Covered Dental Expenses are the Reasonable and Customary charges made by a Dental Practitioner for necessary care, Appliances or other dental materials, as listed below. Dental services not listed below may be covered, at the Plan Administrator's discretion, if they are not excluded. An unlisted dental service must be appropriate dental care performed according to accepted standards of dental practice for the conditions being treated. The Plan Administrator will determine the payment for these unlisted dental procedures based on suitable procedures listed below. The amount payable will be determined according to the terms of the Plan.

For Class III services, payment for a covered replacement of an Appliance or Prosthetic Device, Crown, cast Restoration or fixed Bridge will be based on an appropriate allowance for a like prosthesis.

A temporary service will be considered as an integral part of the final service rather than as a separate service.

A Covered Dental Expense is considered as to be incurred according to the following criteria:

- A. for Appliances or changes to Appliances, on the date the master impression is made;
- B. for a Crown, Bridge or cast Restoration, on the date the tooth or teeth are prepared;
- C. for Root Canal Therapy, on the date the pulp chamber is opened; and
- D. for all other dental charges, on the date the service is rendered or the supply is furnished.

Some dental conditions may be treated by one (1) or more methods. In this case, Covered Dental Expenses under this Plan will be based on the least expensive procedure that provides the proper treatment, according to accepted standards of dental practice.

7.2 EXTENSION OF BENEFITS FOR TREATMENTS IN PROGRESS

A Covered Person may be undergoing a Course of Treatment at the time his or her coverage under the dental provisions of this Plan would otherwise terminate. If so, dental coverage for that Course of Treatment may be continued for up to three (3) months from the date the individual's coverage terminates. This extensions shall not apply to any treatment which was not included in the original Course of Treatment. The extension shall not apply if coverage was terminated due to any of the following:

- A. termination of the Plan dental benefits;
- B. termination of the Plan dental benefits for the class of employees to which the Participant belongs; or
- C. non-payment of any required Participant Contribution for the coverage.

7.3 PREDETERMINATION OF BENEFITS

Predetermination of benefits should be obtained whenever charges for a course of dental treatment will exceed the amount listed in Section 2.5, except for emergency treatment of an accidental Injury.

The Benefit Manager, as the designee of the Plan Administrator for claims, will review the Treatment Plan and determine the amount of covered charges. The Treatment Plan is then returned to the Dental Practitioner showing an estimate of the amount of benefits payable. This

allows the Covered Person to know in advance if alternative treatments are recommended, and approximately how much out of pocket expense he or she will incur.

A predetermination of benefits is not a guarantee of payment under this Plan. Actual benefits will be based on the services performed, the patient's eligibility, the documentation submitted by the Dental Practitioner at the time the claim is submitted and the Plan provisions in effect at the time the charges are incurred.

7.4 CLASS I (PREVENTIVE AND DIAGNOSTIC) – COVERED EXPENSES

The following services are covered as Class I services, subject to the coinsurance listed in Section 2.3, the Calendar Year maximum listed in Section 2.4, and the limitations listed below:

- A. periodic oral examinations, limited to two (2) per Calendar Year;
- B. x-rays not related to Orthodontic Treatment which are performed to diagnose a dental problem or to check the progress of treatment, including:
 - 1. full-mouth x-rays, intraoral or panoramic, limited to one (1) series in a three (3) year period;
 - 2. Bitewing x-rays, limited to two (2) charges in any Calendar Year; and
 - 3. periapical x-rays;
- C. dental/periodontal Prophylaxis, with or without oral examination, limited to two (2) in a Calendar Year;
- D. Topical Application of stannous Fluoride, limited to Dependent children under age fifteen (15);
- E. diagnostic casting;
- F. emergency Palliative treatment;
- G. pulp vitality tests; and
- H. pulpotomy.

7.5 CLASS II (BASIC) - COVERED EXPENSES

The following services are covered as Class II services, subject to the Deductible listed in Section 2.2, the coinsurance listed in Section 2.3, the Calendar Year maximum listed in Section 2.4, and the limitations listed below:

- A. necessary examinations by dental specialists;
- B. fillings, including:
 - 1. sedative;
 - 2. Amalgam;
 - 3. Silicate cement;
 - 4. Acrylic or plastic; or
 - 5. Composite acrylic resin;
- C. pin retentions;
- D. Periodontal procedures, subject to the limitations listed in Section 2.4, including:
 - 1. subgingival curettage or root planing and scaling;
 - 2. correction of occlusion related to periodontal surgery, per quadrant;
 - 3. apicoectomy;
 - 4. gingivectomy or gingivoplasty, per quadrant;
 - 5. osseous surgery, per quadrant;

6. periodontal scaling of twelve (12) or more teeth.
If more than one (1) periodontal service is performed per quadrant, only the most inclusive surgical service performed will be considered as a Covered Dental Expense under this Plan. Flap entry and closure is considered part of the dental service for osseous surgery and osseous graft;
- E. Sealants, limited to Dependent children under age fourteen (14), to posterior teeth, and to not more than once per tooth per thirty-six (36) month period;
- F. space maintainers, including any adjustments within six (6) months of installation;
- G. oral surgery, including local anesthesia and routine postoperative care for:
 1. extractions, simple or surgical. Extractions related to Orthodontic Treatment are not covered under this Plan;
 2. alveolar or gingival reconstructions;
 3. cysts and neoplasms (incision and drainage of an abscess or removal of a cyst or tumor);
 4. sialolithotomy (removal of salivary calculus);
 5. closure of salivary fistula;
 6. dilation of salivary duct;
 7. transplantation of tooth or tooth bud;
 8. removal of a foreign body from bone (independent procedure);
 9. maxillary sinusotomy for removal of tooth fragment or foreign body;
 10. closure of oral fistula of maxillary sinus;
 11. sequestrectomy for osteomyelitis or bone abscess, superficial;
 12. crown exposure to aid eruption;
 13. removal of a foreign body from soft tissue;
 14. frenulectomy;
 15. suture of a soft tissue Injury; and
 16. treatment of trigeminal neuralgia by injection into the second and third divisions.
- H. endodontic treatments, including:
 1. Root Canal Therapy, with Treatment Plan and follow-up care; and
 2. apicoectomy, considered a separate service if performed with Root Canal Therapy;
- I. General Anesthesia when provided in conjunction with covered Surgical Procedures. The anesthetic agent must produce a state of unconsciousness with absence of pain over the entire body. Injections must be administered by an attending Physician; and
- J. necessary prescription drugs. Injections must be administered by an attending Physician or ordered by prescription.

7.6 CLASS III (MAJOR) – COVERED EXPENSES

The following services are covered as Class III services, subject to the Deductible listed in Section 2.2, the coinsurance listed in Section 2.3, the Calendar Year maximum listed in Section 2.4, and the limitations listed below:

- A. any of the following when regular fillings (as listed under Class II) are not adequate to restore the tooth:
 1. gold Inlay fillings or Onlays;
 2. single Crown Restorations in porcelain or cast gold; or
 3. stainless steel Crowns;

- B. the initial installation of Dentures or fixed Bridgework;
- C. alteration, repair or adjustment of Dentures or fixed Bridgework;
- D. the replacement or modification of existing Dentures, fixed Bridgework or cast Restorations only if:
 - 1. the replacement is necessary due to an Injury requiring oral surgery; or
 - 2. oral surgery involving the repositioning of muscle attachments, or the removal of a tumor, cyst, torus or redundant tissue; and
- E. Reline or Rebase of Dentures.

Temporary services, including Dentures and Crowns, will be considered as an integral part of the final service and not covered as a separate service.

7.7 CLASS IV (ORTHODONTIC) – COVERED EXPENSES

Orthodontic Treatment is covered for Dependent children up to age nineteen (19) only. Covered Expenses for Orthodontic Treatment will be paid subject to the Deductible listed in Section 2.2, the Class IV coinsurance listed in Section 2.3 and the Lifetime maximum listed in Section 2.4.

Covered Expenses for Orthodontic Treatment include the Reasonable and Customary expenses for the following:

- A. preliminary study involving x-rays, diagnostic casts and the Treatment Plan;
- B. removal of teeth;
- C. minor treatment and Appliances to control harmful habits; and
- D. correction of Malocclusion by wire Appliances, braces and other mechanical aids.

ARTICLE VIII
VISION BENEFITS

8.1 VISION BENEFITS – COVERED EXPENSES

The Plan will provide benefits for vision expenses, subject to the provisions listed in Section 2.6. Covered vision expenses include:

- A. routine eye examinations performed by a licensed ophthalmologist or optometrist; and
- B. necessary eyeglasses and frames prescribed by such providers. Safety glasses and contact lenses (including disposable contact lenses) are covered under this benefit to the extent the charge does not exceed the maximum Calendar Year benefit under this Plan.

A covered vision care expense is considered to be incurred, as follows:

- A. for eye examinations, on the date the examination is performed;
- B. for lenses, on the date the lenses are ordered; and
- C. for frames, on the date the frames are orders.

Exclusions and limitations which apply to the vision coverage are listed in Section 9.1 and Section 9.3.

ARTICLE IX
EXCLUSIONS AND LIMITATIONS

9.1 GENERAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Persons and to all benefits provided by this Plan, including dental and vision benefits. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided under this Plan, or that the exclusion is prohibited under any applicable law. Exclusions which apply only to the dental coverage are listed in Section 9.2. Exclusions which apply to the vision benefits are listed in Section 9.3.

- A. Charges related to any Injury or Illness resulting from any occupation or employment for wage or profit, or which is covered under any workers' compensation or similar law.
- B. Charges for services rendered by a Close Relative or a person who legally resides with the Covered Person requiring treatment.
- C. Charges for services or supplies which are incurred at a time when no coverage is in force for that person, except as specified in the Plan.
- D. Charges for which the Covered Person has no legal obligation to pay, or for which no charge would have been made in the absence of this coverage.
- E. Charges to the extent they exceed the Reasonable and Customary charge for the service or supply in question.
- F. Charges related to Illnesses or Injuries incurred as a result of war, declared or undeclared, or any act of war or act of aggression by any country.
- G. Charges to the extent they exceed any maximum benefit listed in this Plan.
- H. Charges incurred as a result of the Covered Person's voluntary participation in a riot.
- I. Charges for any treatment, services or supplies which are not specifically set forth as covered under this Plan.

9.2 DENTAL BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to all dental expenses incurred by all Covered Persons and to all dental benefits provided by this Plan. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided under this Plan, or that the exclusion is prohibited under any applicable law. General exclusions which also apply to the dental coverage are listed in Section 9.1.

- A. Charges for cosmetic dental procedures, including characterization of Dentures and alteration or extraction and replacement of sound teeth to change appearance. This exclusion shall not apply to cosmetic dental work required as a result of an accidental Injury, provided that treatment is completed within one (1) year of the date of the Accident or to charges for the correction of a congenital defect or birth abnormality of a covered Dependent child who was covered under this Plan from birth.
- B. Charges for the replacement of lost, missing or stolen Prosthetic Appliances.
- C. Charges for Experimental dental care, implantology or dental care which is not customarily used or which does not meet the standards set by the American Dental Association.
- D. Charges for dental care paid for or provided by the laws of any government or treatment given in a government owned facility, unless the Covered Person is legally

- required to pay for such charges, or as this exclusion is specifically prohibited by applicable law.
- E. Charges for oral hygiene instruction, plaque control programs or dietary instruction.
 - F. Charges for altering Vertical Dimension, Splinting or restoring Occlusion or replacement of tooth structure lost because of abrasion or attrition, except as considered a Class IV expense under this Plan.
 - G. Charges for myofunctional therapy.
 - H. Charges for athletic mouthguards.
 - I. Charges for services or supplies which are not recommended by a Dentist or Physician.
 - J. Charges for Orthodontic Treatment and Appliances for other than Dependent children.
 - K. Charges related to the treatment of Temporomandibular Joint (TMJ) Dysfunction or Disorder.
 - L. Charges to the extent that they are in excess of the least expensive treatment which meets recognized dental standards.
 - M. Charges for Dentures, Bridges or Crowns if impressions were taken or preparations made prior to the date the person became a Covered Person under this Plan.
 - N. Charges for Root Canal Therapy if the active therapy began before the date the person became a Covered Person under this Plan.
 - O. Charges for customization of Prosthetic Appliances or Restorations.

9.3 VISION BENEFIT EXCLUSIONS AND LIMITATIONS

The following exclusions and limitations apply to all vision benefits provided by this Plan. Any exclusion listed below shall not apply to the extent that coverage for the service or supply is specifically provided under this Plan, or that the exclusion is prohibited under any applicable law. General exclusions which also apply to the vision coverage are listed in Section 9.1.

- A. Charges for services or supplies provided primarily for cosmetic or aesthetic purposes. This exclusion does not apply to charges for contact lenses which are prescribed to correct refractive errors.
- B. Charges for a visual analysis which does not include a refraction.
- C. Charges for Experimental vision care, or vision care which is not customarily used or which does not meet normal standards.
- D. Charges for medical or surgical care and treatment of the eyes.
- E. Charges for plano (non-prescription) lenses, and frames to be used with lenses which do not require a prescription.
- F. Charges for orthoptics or vision training.

ARTICLE X GENERAL INFORMATION

10.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare Part A or Part B or other types of insurance. A Covered Person may have coverage under this Plan, some other health plan of coverage or other kind of insurance policy at the same time. Other health plans of coverage include a group sickness and Accident insurance policy or program, a group contract of a health maintenance organization, an individual sickness and Accident insurance policy and an individual contract of a health maintenance organization. Other kinds of insurance policies include your automobile insurance policy's medical payments and uninsured motorist's coverage. For example, a person may be covered by an employer's group insurance program and also by the group program provided by a spouse's employer. Or a person may be covered by an employer's group insurance and also have coverage under a parent's group plan.

If a Covered Person files a claim under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan(s) or insurance policy will be no more than the usual, Customary, and Reasonable fee payments.

Once a Covered Person has provided this Plan with information about other health benefits plans and health benefits under other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination works as follows:

- A. The plan that pays first is called the primary plan. Any other plan that covers the Covered Person is called the secondary plan. A group or individual plan or policy that does not contain a COB feature is always primary.
- B. A plan that covers a person as the certificate holder or the contract holder is primary. In the two examples given, the coverage the person has through his or her employer would be primary. The coverage through a spouse's or parent's employer would be secondary.
- C. If a person is covered as a Dependent child of two working parents, the plan of the parent whose birthday falls earliest in the year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose coverage has been in effect the longest is primary. The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule." If divorced or separated parents (and/or their current spouses) each have group health care coverage that includes a Dependent, the order of benefit determination will be determined, as follows:
 1. the plan of the custodial parent, if any, shall pay its benefits first;
 2. the plan of the spouse of the custodial parent, if any, will pay next;
 3. the plan of the non-custodial parent, if any, will pay after the prior listed plans; and
 4. the plan of the spouse of the non-custodial parent, if any, shall pay its benefits last.

However, if a court order establishes responsibility for payment of health care benefits with the parent who does not have custody of the Dependent and the entity that would be obligated to pay the benefits has actual knowledge of the court order's terms, the plan of such non-custodial parent shall pay its benefits before any of the other plans listed above.

- D. A plan that covers a person as an active employee or as a dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a dependent of a laid-off or retired employee.
- E. There are some situations in which none of these rules apply. Here the program that has been in effect longer is primary. An example would be when a person who works two jobs has health coverage through both employers.
- F. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile Accident with an uninsured motorist, his or her automobile policy's uninsured motorist's coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

If coverage under this Plan is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, this Plan's payments will be calculated by subtracting the primary plan's benefits for the services and supplies covered under this Plan from the usual, customary and reasonable allowance for the services and supplies. Of course, the Plan will not pay more when secondary than it would if primary. By accepting coverage under this Plan, a Covered Person agrees to do two things to enable the Plan to coordinate benefits. First, the Covered Person will supply the Plan with information about other coverage he or she has when asked. Second, if the Plan makes a payment and later finds out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e., insurance companies and other persons, for instance.

10.2 RIGHT OF RECOVERY

Immediately upon paying or providing any benefit under this Plan, the Plan shall be subrogated to all rights of recovery a Covered Person has against any party potentially responsible for making any payment to a Covered Person due to a Covered Person's injuries or illness, to the full extent of benefits provided or to be provided by this Plan.

In addition, if a Covered Person receives any payment from any potentially responsible party as a result of an injury or illness, the Plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount the Covered Person receives from all potentially responsible parties. The Covered Person agrees that if he/she receives any payment from any potentially responsible party as a result of an injury or illness, he/she will serve as a constructive trustee over the funds. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

Further, the Plan will automatically have a lien, to the extent of benefits advanced, upon any recovery whether by settlement, judgment or otherwise, that a Covered Person receives from a third party, the third party's insurer or any other source as a result of the Covered Person's injuries. The lien is in the amount of benefits paid by this Plan for the treatment of the illness, injury or condition for which another party is responsible.

As used throughout this provision, the term "responsible party" means any party possibly responsible for making any payment to a Covered Person due to a Covered Person's injuries or illness or any insurance coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverages, personal umbrella coverage, medical payments coverages, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The Covered Person acknowledges that this Plan's recovery rights are a first priority claim against all potentially responsible parties and are to be paid to the Plan before any other claim for the Covered Person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a

recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. It is further agreed that the Plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the Covered Person to pursue the Covered Person's damage claim.

The terms of this entire right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided. The Plan is entitled to recover from *any* and *all* settlements or judgments, even those designated as pain and suffering or non-economic damages only.

The Covered Person shall fully cooperate with the Plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the Plan Administrator within thirty (30) days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages or obtain compensation due to injuries or illness sustained by the Covered Person. The Covered Person shall provide all information requested by the Plan Administrator, the Benefit Manager or the representative of either of these including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request. Failure to provide this information shall be deemed a breach of contract, and may result in the termination of health benefits or the instigation of legal action against the Covered Person.

The Covered Person shall do nothing to prejudice the Plan's recovery rights as herein set forth. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan.

In the event that any claim is made that any part of this right of recovery provision is ambiguous or questions arise as to the meaning or intent of any of its terms, the Covered Person and the Plan agree that the Plan Administrator shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

The Covered Person agrees that any legal action or proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan Administrator may elect. Upon receiving benefits under this Plan, the Covered Person hereby submits to such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

10.3 ADDITIONAL RIGHTS OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant.

This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

10.4 FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager shall be under any obligation

to see that a legal representative is appointed or to make payments to such legal representative, if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

10.5 ADMINISTRATION OF THE PLAN

Except as otherwise specifically provided for in the Plan, the Plan Administrator shall have the exclusive authority to control and manage the operation and administration of the Plan and shall be Named Fiduciary of the Plan for purposes of ERISA. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA and all other applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

- A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;
- B. to construe and interpret this Plan;
- C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;
- D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;
- E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;
- F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;
- G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;
- H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;
- I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of ERISA and all other applicable laws, and all regulations promulgated thereunder; and
- J. to retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan

Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

10.6 NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider; provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

- A. the Plan Administrator or Benefit Manager is notified of such assignment prior to payment of benefits;
- B. the assignment is made on a form provided by, or approved by, the Plan Administrator or the Benefit Manager; and
- C. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or Benefit Manager.

10.7 FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

10.8 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under ERISA and other applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in ERISA and other applicable laws.

10.9 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan.

Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any provider of services or supplies under this Plan. Neither the Plan, nor the Plan Administrator, nor the Benefit Manager have any responsibility for or control over the actions of any Preferred Provider networks offering services and/or supplies under the Plan.

10.10 ADMINISTRATIVE AND CLERICAL ERRORS

The benefits payable to or on behalf of a Participant or Dependent under this Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Benefit Manager. If written application for coverage for an eligible employee or Dependent is submitted by the employee/Participant within the applicable time frame specified in Article V, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Benefit Manager shall not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in claims processing, utilization review or other administrative functions shall not affect the benefits payable to or on behalf of a Covered Person under this Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator shall have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

ARTICLE XI

PRIVACY

11.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

11.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one of (1) the following conditions:

- A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;
- B. for payment of claims submitted to the Plan, including, but not limited to, the review of any grievances or appeals involved in such activities which are generated by the Covered Person or his or her authorized representatives;
- C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:
 1. quality assessment and improvement activities;
 2. evaluation of Plan performance;
 3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
 4. conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
 5. business planning and development of the Plan;
 6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
 7. other health care operations listed under 45 C.F.R. § 164.501.

No other use or disclosure of Protected Health Information is permitted by this Plan.

11.3 DISCLOSURES OF HEALTH INFORMATION TO THE COMPANY

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the Company only as described below:

- A. for any of the purposes and under the conditions described in Section 11.2;
- B. as Summary Health Information, if requested by the Company for the following purposes:
 1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
 2. modifying, amending or terminating the Plan; or
- C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Company for the purpose of performing Plan administrative functions;

Prior to any disclosure of Health Information to the Company, such entity must agree:

- A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;
- B. that it will ensure that any agents, including subcontractors, employed by the Company or Plan Administrator for Plan administration or other Plan purposes to whom it provides Protected Health Information, including, but not limited to, the Benefit Manager, agree to the same restrictions and conditions that apply to the Company with respect to such information;
- C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Company; and
- D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;
- E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 11.4 and Section 11.5;
- F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;
- G. that it will make available its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;
- H. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and
- I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:
 1. access to Protected Health Information will only be provided to the following categories of Company employees:
 - a. the Director of Human Resources;
 - b. the Benefits Specialist;
 - c. the Payroll Staff Accountant; and
 - d. the Payroll Manager/HR associate,
 2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the Company performs for the Plan; and
 3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Company's established employee discipline and termination procedures.

11.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

- A. psychotherapy notes;
- B. information compiled in reasonable anticipation, or for use in, a civil, criminal or administrative proceeding or action; or
- C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524.

Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

11.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the Company amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

- A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;
- B. the information is not currently maintained in any record by the Plan;
- C. the information would not be available for inspection under the reasons cited in Section 12.4; or
- D. the information in the Plan's records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity's receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

11.6 SECURITY OF PROTECTED HEALTH INFORMATION

The Company will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Company and the Plan to support the requirements of Section 11.3. The Company will further ensure that any agent, including a subcontractor, to whom it provides access to Protected Health Information agrees to

implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.

ARTICLE XII

STATEMENT OF ERISA RIGHTS (Required by Federal Law and Regulations)

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

A. Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a copy 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.

B. Continue Group Health Plan Coverage:

1. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation rights.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health Plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition exclusion for the time period listed in Section 9.2 after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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.

D. Enforce Your Rights:

1. 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.
2. 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 thirty (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 one hundred ten dollars (\$110.00) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit, once the other appeal rights listed in this Plan are exhausted, in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. 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 (formerly Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance and Communications, 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.

IN WITNESS WHEREOF, the revised Antioch University Employee Group Benefit Plan - Supplemental Plan is adopted, by execution hereof, effective as of January 1, 2011.

By

Antioch University

Date

Witness

Date