Employee Benefit Plan

Plan Document/
Summary Plan Description

Dental Plan

Amended and Restated
effective January 1, 2020

This SPD supersedes any previous printed or electronic SPD for this Plan.

www.tlcbenefitsolutions.net

DENTAL PLAN
TABLE OF CONTENTS

1. INTRODUCTION

In this document, capitalized terms have a special meaning. You should refer to the Defined Terms section for the definitions of any capitalized terms.

The Langdale Company is the Plan Sponsor of the Langdale Company Employee Benefit Plan (the Plan). The Plan is a self-funded plan, meaning that a Participating Employer pays claims with its own funds from its general assets.

The Plan provides dental benefits to eligible Employees and their Dependents. The Plan is a welfare benefit plan, as defined under the Employee Retirement Income Security Act of 1974 (ERISA).

How to Use This Document

The Plan Sponsor is pleased to provide you with this Summary Plan Description/Plan Document (SPD), which describes the benefits available under the Plan. The SPD includes information regarding:

- who is eligible;
- services that are covered;
- services that are not covered;
- how benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements under federal law. Please take the time to read and understand how the benefits of the Plan affect you. As you read this document, please keep in mind that the written terms will govern whatever benefits you receive under the Plan. No oral interpretations can change this Plan.

If you have questions regarding the Plan, please contact the Plan Administrator: TLC Benefit Solutions, Inc., P.O. Box 947, Valdosta, GA 31603. Phone: (229) 249-0940, Toll-free: (877) 949-0940.

Not an Employment Contract

The Plan shall not be deemed to constitute an employment contract with any Participating Employer. Participation in the Plan does not guarantee employment or continued employment with a Participating Employer.

2. ELIGIBILITY, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. ELIGIBILITY

Eligible Class of Employees. All Full-Time Active Permanent Employees of a Participating Employer. Full-Time Active Permanent refers to an Employee who is regularly scheduled to work at least 30 hours per week. Seasonal Employees, part-time Employees, volunteers, and independent contractors are excluded.

Individuals who are shareholders of the Langdale Company and its subsidiaries are eligible to participate in the Plan.

Eligibility Requirements for Employee Coverage. An Employee is initially eligible for Plan coverage from the first day that he or she meets all of the following requirements:

(1) Is in an Eligible Class of Employees.

(2) Completes the employment Waiting Period as a member of an Eligible Class of Employees.

Eligible Classes of Dependents. An eligible Dependent is any one of the following persons:

(1) A covered Employee's Spouse

(2) A covered Employee's Child or covered Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child, or a child for whom you or your Spouse are the legal guardian; or

(3) An unmarried Child age 26 or over who is or becomes Totally Disabled and dependent upon you. The Plan Administrator may require at reasonable intervals during the two years following the Child's reaching the limiting age, subsequent proof of Total Disability and continuing to meet the definition of Child and other terms of this coverage. After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of Total Disability.

(4) A child for whom health care coverage is required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order. Please see the Qualified Medical Child Support Order (QMCSO) section for more details.

Excluded from Eligible Classes of Dependents.
These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any Child born to a Dependent Child; any person who is on active duty in any military service of any country; any person who is a resident of another country outside the United States; or any person who is covered under the Plan as an Employee.

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

If both husband and wife are Employees, their Children will be covered as Dependents of the husband or wife, but not of both.

Eligibility Requirements for Dependent Coverage.
An eligible Dependent of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the eligible Dependent satisfies all requirements for Dependent coverage. Dependent Verification Documentation must be submitted timely.

B. ENROLLMENT

Enrollment Requirements. An eligible Employee must timely enroll for coverage when initially eligible. Enrollment will be "timely" if the completed enrollment application is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage. If an eligible Employee elects to cover eligible Dependents, those Dependents are also required to be timely enrolled at that time.

The Plan does not allow for late enrollment. This means that if an eligible Employee or Dependent does not timely enroll when initially eligible, there will be no coverage in the Plan unless enrollment is later allowed due to a HIPAA Enrollment Event, as described below, or the Employee elects coverage during an Open Enrollment period.

Enrollment Rules if Spouse is Also Employed by a Participating Employer.
If your Spouse is also an employee of a Participating Employer of this Plan, you may each have single coverage or one of you may elect to have family coverage, which will cover your Spouse and any eligible Dependents. You may not have one single coverage and one family coverage or two family coverages.

If you and your Spouse are each enrolled for single coverage, you may change one of the single coverages to a family coverage at any time without restriction, but only those Dependents who were timely enrolled will be covered. The other single coverage will be canceled. If you have family coverage that covers your Spouse and any eligible Dependents, you may transfer the family coverage to your Spouse at any time.

If, at the time of marriage, the employees each have family coverage or one has family coverage and the other has single coverage, coverage must be changed to one of the options listed above within 31 days of marriage. Failure to comply with this requirement may result in denial of claims for eligible Dependents.

If two Employees (husband and wife) are covered under the Plan and the employment of the Employee who is covering a Dependent Child terminates, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee must be timely enrolled in this Plan (i.e., within 31 days after birth) in order to receive coverage. This applies whether the Employee has single coverage or family coverage. Charges for covered nursery care and routine Physician care will be applied toward the Plan of the newborn child. If a newborn child is not enrolled in the Plan on a timely basis, there will be no payment of any kind from the Plan related to the newborn, regardless of whether the baby is well or sick. If the child is not timely enrolled, the Plan will not pay or be responsible for any costs; and the newborn child will not be eligible for mid-year enrollment unless a HIPAA Enrollment Event applies, as described below.

HIPAA Special Enrollment Events. Enrollment is typically permitted only during specified times following initial eligibility and at Open Enrollment; however, the Plan will allow Eligible Employees and Dependents, who previously declined Plan coverage, to enroll in the Plan upon experiencing one of the following special enrollment events listed below. Enrollment is requested by filling out, signing, and returning the enrollment application to the Plan Administrator.

1. **Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).**
   If you declined enrollment for yourself or for an eligible Dependent while other health insurance or group health plan coverage was in effect, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of other coverage due to failure to pay premiums or for cause (such as making a fraudulent claim) does not qualify for special enrollment rights. Coverage will become retroactively effective as of the date of the special enrollment event.

2. **New Dependent by Marriage, Birth, Legal Guardianship, A Foster Child Being Placed With an Employee, Adoption, or Placement for Adoption.** If you have a new Dependent as a result of marriage, birth, legal guardianship, a foster child being placed with an Employee, adoption, or placement for adoption, you may be able to enroll yourself and your new Dependents. However, you must request enrollment within 31 days after the marriage, birth, legal guardianship, a foster child being placed with an Employee, adoption, or placement for adoption.

If enrollment is timely requested, coverage will become retroactively effective as of the date of the special enrollment event.

3. **Loss of Coverage for Medicaid or a State Children's Health Insurance Program.**
   If you declined enrollment for yourself or for an eligible Dependent while Medicaid coverage or coverage under a state children's health insurance program was in effect, you may be able to enroll yourself and your Dependents in this plan if you or your Dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your Dependents' coverage ends under Medicaid or a state children's health insurance program. Coverage will become effective as of the 1st day following the loss of other coverage.

4. **Eligibility for Medicaid or a State Children's Health Insurance Program.**
   If you or your Dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, you may be able to enroll yourself and your Dependents in this Plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. Coverage will become effective as of the day you or your Dependents become eligible for the state premium assistance.

Change of Election Under Flexible Benefits Plan. If a situation occurs that would allow an election change under The Langdale Company Flexible Benefits Plan to begin coverage under a dental plan, then this Plan will allow special enrollment period attributable to and consistent with that authorized change of election, provided all requirements of the Flexible Benefits Plan and this Plan are met. For a copy of the Flexible Benefits Plan, please contact the Plan Administrator.

Special enrollment periods and election changes under this Plan must be timely requested within 31 days of the authorized Flexible Benefits Plan event by filling out, signing, and returning an enrollment application to the Plan Administrator. If such changes are timely requested, coverage will become effective under this Plan as of the day a qualifying event under Flexible Benefits Plan occurs, unless otherwise provided by law.

C. EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the date that the Employee satisfies the

Eligibility requirements and the Enrollment requirements of the Plan. If an Employee enrolls in a HIPAA Enrollment Event, cover- age will become effective as explained above in that Section.

Effective Date of Dependent Coverage. A Dependent’s coverage will take effect on the day that the Eligibility and Enrollment requirements are met, and the Employee is covered under the Plan. If a Dependent enrolls in a HIPAA Enrollment Event, coverage will

become effective as explained above in that Section.

D. TERMINATION OF COVERAGE

Generally, when your coverage ends, the Plan Administrator will still pay claims for covered services received before coverage ended. However, once coverage ends, claims will not be paid for dental services received after coverage ended, even if the underlying medical condition occurred before coverage ended.

Employee Coverage will end on the earliest of:

- the day employment with a Participating Employer ends;
- the date the Plan is terminated;
- the last day of the month for which the required Employee contribution has been paid if the charge for the next period is not paid when due;
- the day an Employee is no longer eligible; or
- the day the Plan Administrator receives notice from a Participating Employer to end coverage, or the date requested in the notice, if later.

Coverage for an Employee's eligible Dependents will end on the earliest of:

- the date the Plan is terminated
- the date Employee coverage ends for any reason;
- the last day of the month for which the required Employee contribution has been paid if the charge for the next period is not paid when due;
- the day the Plan Administrator receives notice from a Participating Employer to end Dependent coverage, or the date requested in the notice, if later; or
- the day the Dependents no longer qualify as Dependents under this Plan; or
- the end of the month in which the Dependent turns 26 years old.

Other Events Ending Your Coverage. The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent.

Continuing Coverage Through COBRA. If an Employee and/or Dependents lose Plan coverage, coverage continuation options may be available under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Please see the COBRA Continuation Options section of the SPD.

Employees on Military Leave. An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Covered Person and the Covered Person's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). Please see the Other Federal Laws That Apply section in this SPD or ask your Plan Administrator for details.

Continuation During Employer-Approved Leaves of Absence (Non-FMLA). Notwithstanding the above termination date, a covered Employee may remain eligible for

a limited time if coverage would otherwise terminate, but the Employee is on an Employer-approved leave of absence and employment has not terminated.

The limited time of continuation is up to 12 weeks provided that the Employee remains on an Employer-approved leave of absence. For coverage to continue, any contribution required of the Employee must continue to be made during this period. It is intended that this limited continuation will run concurrently with any continuation of medical benefits that may be required under the Family and Medical Leave Act. If coverage would terminate earlier than 12 weeks under any other provision of this Plan, then the earlier termination provision of the Plan will take precedence. While coverage is continued, the coverage provided would be the same that was in force on the last day the Employee was actively at work. However, any changes that may be made to the Plan during the period of limited continuation, including any change in the required Employee contribution, will also apply to those who are receiving limited continuation.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 ("FMLA") as promulgated in regulations issued by the Department of Labor, notwithstanding anything to the contrary in the Plan. If the Participating Employer is covered by the FMLA, then during any leave taken under the FMLA, the Employee will be eligible to maintain coverage under this Plan on the same conditions as coverage would have been available if the covered Employee had been actively employed during the FMLA leave period. It is intended that where appropriate, the period of medical coverage required by the FMLA will run concurrently with the limited continuation provided in the preceding section.

If Plan coverage terminated during the period of the FMLA leave (e.g. for Employee's failure to pay premiums while on FMLA leave), coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her covered Dependents when Plan coverage terminated.

It is intended that this section regarding the FMLA shall be interpreted in accordance with the FMLA and not be construed as an expansion or restriction of any of the Employer's or Employee's obligations or rights thereunder.

Reinstatement of Coverage. If employment is terminated and the Employee returns to active employment within 13 weeks from the date of termination, the Waiting Period will be waived and coverage will take effect on the first day the Employee returns to active employment.

All coverage reinstatements will be subject to other terms of the Plan.

3. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

Pursuant to Section 609 (a) of the Employee Retirement Security Act of 1974 (ERISA), this Plan will honor the terms of a Qualified Medical Child Support Order (QMCSO) to the extent required by law.

A QMCSO is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for a child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it is "qualified" – i.e. whether it meets the requirements for a QMCSO. If the Plan determines that a medical child support order is qualified, the child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Plan benefits as directed by the QMCSO. A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

You may obtain, without charge, a copy of the procedures governing QMCSOs, including how to submit a medical child support order to the Plan, from the Plan Administrator by submitting a written request.

4. SCHEDULE OF BENEFITS

VERIFICATION OF BENEFITS

Call this number *to verify benefits and eligibility* for Plan:

TLC Benefit Solutions, Inc. at (229) 249-0940 or toll free at (877) 949-0940.

Verification of benefits is not a guarantee of payment.

DENTAL BENEFITS

Insurance Provided

We will pay benefits for covered dental expenses identified in the Plan when incurred by you or your Dependent, while covered under the Plan. We will pay the coinsurance percentage shown in the Schedule after you or your Dependent have satisfied any deductible required for the Plan year, subject to all the terms and conditions of the Plan.

Covered dental expenses will only include Treatment provided to you or your Dependent for which, as outlined in the Listing of Covered Dental Services provision, the date started and the date completed occur while the person is insured under the Plan. No payment will be made for a program of dental Treatment already in progress on the effective date of a person's insurance. No payment will be made for dental Treatment completed after your or your Dependent's insurance under the Plan ends, except as stated in the Limited Extension of Benefits After Insurance Ends provision.

Deductible

The deductible is the amount shown in the Schedule and will be applied to each type of dental services as indicated in the Schedule. The deductible is the amount of covered dental expenses that you and each Dependent must incur in a policy year before the Plan will pay benefits. When covered dental expenses equal to the deductible amount have been incurred and submitted to us, the deductible will be satisfied. We will not pay benefits for covered dental expenses applied to the deductible.

If the deductible amount is increased during a Policy Year, further covered dental expenses must be incurred after the date of increase to satisfy the additional deductible for that Policy Year.

The deductible will apply to you and each Dependent separately each Plan Year.

Policy Year Maximum

The maximum benefit payable to you and each Dependent during a Plan Year is shown in the Schedule. This maximum will apply even if coverage for you or your Dependent ends and starts again within the same Policy Year or if you or your Dependent have been covered both as an Employee and a Dependent.

Date Started and Date Completed

We consider a Dental Treatment to be started as follows:

- for a full or partial denture, the date the first impression is taken;
- for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
- for root canal therapy, on the date the pulp chamber is first opened;
- for periodontal surgery, the date the surgery is performed; and
- for all other Treatment, the date Treatment is rendered.

We consider a Dental Treatment to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed partial denture, crown, inlay and onlay, the date an appliance is cemented in place; and
- for root canal therapy, the date a canal is permanently filled.

Pre-estimate

Whenever the expected cost of a Treatment exceeds $300, we recommend that a Dental Treatment Plan be submitted to us for review before Treatment begins. The Dental Treatment Plan should be accompanied by supporting preoperative x-rays and any other appropriate diagnostic materials as requested by us. We will notify you and your dentist of the benefits payable based upon the Dental Treatment Plan. In estimating the amount of benefits payable, consideration will be given to the least costly alternative procedures and materials that may accomplish a result that meets broadly accepted standards of professional dental care.

If a Dental Treatment Plan is not completed within six months of the pre-estimate, we may consider it invalid. We may request the submission of a new dental treatment plan.

If you and your Dentist decide on a more costly method of Treatment than that pre-estimated by us, benefits payable for covered dental services for the more costly Treatment will be limited to the benefits that would have been payable for covered dental services for the least costly alternative Treatment. We will not pay the excess amount. Since this may result in significant out- of-pocket expense, we strongly encourage you to receive a pre-estimate for any Dental Treatment Plan that is expected to exceed $300 in cost.

Alternative Benefits

In determining the benefits payable on a claim, we will consider other alternative procedures and materials that can be used to treat a dental problem or disease. The covered dental expense for a covered dental service provided will be limited to the Allowable Charge for the least costly covered dental service that accomplishes a result which meets broadly accepted standards of professional dental care. You and your Dentist may decide on a more costly procedure or material than we have

determined to be satisfactory for the Treatment of the dental problem or disease. In this event, we will not pay the excess amount. The benefit payable will be limited to the benefit that would have been payable had the least costly covered dental service been provided instead.

Covered Dental Expenses

Covered dental expenses include only the lesser of the Dentist's actual charge or the Allowable Charge for expenses incurred by you or your Dependent. The Treatment must be:

- performed by or under the direction of a dentist, or performed by a dental hygienist or denturist;
- Dentally Necessary; and
- started and completed while you or your Covered Dependent are insured, except as otherwise provided in the Limited Extension of Benefits After Insurance Ends provisions.

Expenses submitted to us must identify the Treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request X-rays, narratives and other diagnostic information, as we see fit, to determine benefits.

We will only pay benefits for covered dental expenses incurred for treatment that, in our opinion, has a reasonably favorable prognosis for the patient.

We consider a temporary Treatment to be an integral part of the final Treatment. The sum of the fees for temporary and final Treatment will be used to determine whether the charges are an Allowable Charge.

The Listing of Covered Dental Services is a complete list of covered dental services. We will not pay benefits for expenses incurred for any service not listed below, unless we agree to accept an unlisted service as a covered dental service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. In any event, the choice of whether or not to accept an unlisted service is solely ours. If we do accept an unlisted service as a covered dental service, benefits will be payable on a basis consistent with benefits for similar covered dental services which would provide the least costly adequate treatment of your or your covered dependents dental condition according to broadly accepted standards of professional dental care.

Listing of Covered Dental Services

Maximum frequencies, maximum dollar amounts and other limits are shown here and under Special Limitations and General Exclusions for certain services. Services performed outside these limits are not covered dental services. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the Listing of Covered Dental Services. However, benefits will be payable based on the most current dental terminology.

Type I Dental Services

- Clinical Oral Evaluations
  - No more than 1 time in any 6 months in a row. Benefits are based on the Allowable Charge for periodic oral evaluation.
- Dental Prophylaxis
  - No more than 1 time in any 6 months in a row.

- Topical Fluoride Treatment
  - No more than 1 time in any 12 months in a row. Only for children under age 14 years.

- Sealants
  - No more than 1 time per tooth per person. Only for children under age 16 years.

- Space Maintenance (Passive Appliances)
  - Only for children under age 16 years. Service is deemed to include all adjustments made, or recementing done, within 6 months of installation.

- Treatment to Control Harmful Habits
  - Not covered if orthodontic related. Once per person. Only for children under age 16 years.

- Radiographs-Diagnostic Imaging
  - Bitewings - No more than 1 time in any 12 months in a row.

Type II Dental Services

- Radiographs-Diagnostic Imaging
  - Complete Series (including Full Mouth or Panoramic Film) - No more than 1 time in any 36-month period. A complete series is deemed to include bitewing x-rays and 10 or more periapical x-rays, or a panoramic film.
    - One of either services no more than 1 time in any 36 months in a row. Benefits for a panoramic film may also be payable in connection with the removal of impacted teeth.
  - Periapical - No more than 4 X-rays in any 12 months in a row, unless determined to be Dentally Necessary.
  - Occlusal Film - No more than 2 films in any 12 months in a row, unless determined to be Dentally Necessary.
  - Extraoral - No more than 2 films in any 12 months in a row, unless determined to be Dentally Necessary
  - Sialography

- Minor Restorations (Fillings)
  - Amalgam and Composite Restorations
    - Replacement of existing minor restoration (filling) is deemed to be a covered dental service only if at least 24 months have passed since existing minor restoration (filling) was placed, unless required by new decay in an additional tooth surface.
    - The service is deemed too include local anesthesia.
    - Multiple restorations on one surface are deemed to be a single restoration.

- Mesial-lingual, distal-lingual-mesial-facial, and distal-facial resin restorations on anterior teeth are deemed to be single surface restorations.

- Limited Oral Exam

- Other Restorative Services
  - Pin Retention - No more than 1 time per restoration. Deemed to be a covered dental service only in conjunction with amalgam or resin restoration.

- Oral Surgery
  - Minor Oral Surgery - Each service is deemed to include local anesthesia and routine postoperative care.

    - Simple Extractions (Does not include Surgical Extractions)

    - Surgical Incision and Drainage of Abscess

    - Root Removal - Exposed Roots

- Other Type II Services
  - Bacteriologic Studies for Determination of Pathologic Agents

  - Palliative (Emergency) Treatment of Dental Pain - Minor Procedure deemed to be a separate covered dental service only if no other service is rendered during the visit, except x-rays.

  - Therapeutic Drug Injection

  - Histopathologic Examinations

Type III Dental Services

- Complex Oral Surgery
  - Surgical Extractions

- Full Mouth Debridement- No more than 1 time in any 12 months in a row

- Other Complex Oral Surgery Procedures
  - Oroantral Fistula Closure

  - Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth and/or Alveolus

  - Tooth Transplantation

  - Surgical Exposure of Impacted or Unerupted Tooth to Aid Eruption

  - Biopsy of Oral Tissue

- Transseptal Fiberotomy
- Alveoplasty
- Vestibuloplasty
- Removal of Exostosis
- Removal of Foreign Body, Skin, or Subcutaneous Areolar Tissue
- Removal of Reaction-Producing Foreign Bodies Musculosketal System
- Maxillary Sinusotomy for Removal of Tooth Fragment or Foreign Body
- Frenulectomy (frenectomy or Frenotomy) Separate Procedure
- Excision of Hyperplastic Tissue - Per Arch
- Excision of Pericoronal Gingiva
- Sialolithotomy
- Excision of Salivary Gland
- Sialodochoplasty
- Closure of Salivary Fistula

    - If more than one complex surgical procedure is performed per area of the mouth, only the most inclusive surgical procedure performed will be con sidered a covered dental expense.

- Adjunctive General Services - Each service is deemed a separate covered dental service only when medically required for a complex oral surgery which is itself a covered dental service. Our decision is final for the purposes of determining covered dental services under the policy.

    - Anesthesia
    - Intravenous Sedation

- Endodontics - For applicable procedures, the service is deemed to include all pre-operative, operative, and post-operative X-Rays, local anesthesia, and routine follow-up care.
    - Pulpotomy - Only for Deciduous Teeth
    - Endodontic therapy
    - Endodontic retreatment Service is deemed a covered dental service if at least 24 months have passed since the initial treatment.

- ❍ Apexification-Recalcification procedures
- ❍ Apicoectomy surgery
- ❍ Periradicular services
  - Retrograde Filling
  - Root Amputation

- Other Endodontic Procedures
  - ❍ Hemisection (Including any Root Removal), Not including Endodontic Therapy - covered dental services do not include fixed partial dentures replacing the extracted part of a hemisected tooth.

- Minor Periodontics
  - ❍ Adjunctive periodontal service
    - Provisional Splinting - covered dental services do not include inlays, onlays, crowns, or other cast or prepared restorations made for the purpose of splinting.
    - Scaling and Root Planing - No more than 1 time per area of the mouth in any 12 months in a row. The benefit for three or more quadrants of scaling and root planing, performed during the same appointment, will be limited to a full mouth scaling and root planing. Benefits for prophylaxis and scaling and root planing, performed during the same appointment, will be based on the allowable charge for a prophylaxis. Benefits for scaling and root planing and
    - Periodontal maintenance, performed during the same appointment, will be based on the Allowable Charge for periodontal maintenance. Antibiotics are covered in connection with treatment for gum disease.
    - Occlusal adjustment - No more than 1 full mouth treatment in any 12 months in a row. Only when performed with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service.)

- Other Periodontal Services
  - ❍ Periodontal Maintenance – No more than 1 time in any 3 months in a row for treating gum disease. No more than 1 time in any 6 months in a row when used in place of prophylaxis. Service is deemed to include scaling and root planing, a recall evaluation, charting, polishing of teeth, and oral hygiene instruction. Antibiotics are covered in connection with treatment for gum disease.

- Major Periodontics - For applicable procedures, services are deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - ❍ Surgical Services - If more than one periodontal surgical service is performed per area of the mouth, only the most inclusive surgical service performed will be considered a covered dental expense. The following surgeries are covered only if

more than 36 months have passed since gingivectomy, flap surgery, mucogingival surgery, or osseous surgery was performed in that same area of the mouth.

- Gingivectomy or Gingivoplasty
- Gingival Flap Procedure
- Mucogingival Surgery
- Osseous Surgery

❍ Clinical Crown Lengthening

❍ Guided Tissue Regeneration

❍ Soft Tissue Graft

❍ Subepithelial Connective Tissue Graft

❍ Distal or Proximal Wedge

- Major Restorations - Initial (New) or Replacement. For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one-year follow-up care.
  - ❍ Inlay/Onlay Restorations
    - Benefits are based on the allowable charge of a metallic inlay or onlay.
  - ❍ Implants, insertion of implants or related appliances, or surgical removal of implants.
  - ❍ Crowns
    - Benefits are based on the allocable charge for predominantly base metal.
  - ❍ For children under age 16 years, covered dental services for crowns on vital teeth are limited to prefabricated stainless steel or prefabricated resin crowns. Labial Veneers (Only for Anterior Teeth)
  - ❍ Other Restorative Services - Only under unusual circumstances when required for retention and preservation of the tooth. Service is deemed to include pins.
    - Core Build-up, including any pins
    - Cast Post and Core
    - Prefabricated Post and Core
- Complete dentures and partial dentures
  - ❍ Service is deemed to include all replacement teeth and all clasps and rests.

- Fixed Partial Denture Pontics
  - Fixed partial denture retainers - Inlays/onlays and crowns - Benefits based on the allowable charge for predominantly base metal.

    - Two or more contiguous spans of fixed partial denture work, regardless of the number of pontics and abutments involved, are deemed to be a single fixed partial denture with benefits payable based on a single date completed. Benefits for such a fixed partial denture will not be applied to more than one policy year.

- Tissue Conditioning
  - No more than 1 time in any 36 months in a row.

  - Only if at least 12 months have passed since the insertion of a full or partial denture.

- Major Restorations - Maintenance - For applicable procedures, the service is deemed to include local anesthesia, temporary restorations and appliances, and one year follow-up care. Covered only if more than 6 months have passed since the initial insertion.
  - Recement inlays

  - Recement Crown

  - Recement Fixed Partial Denture

- Repairs to complete dentures, partial dentures, or fixed partial dentures
  - Only if more than 6 months have passed since the initial insertion.

- Adjustment to dentures
  - No more than 1 time in any 12 months in a row. Only if more than 6 months have passed since the initial insertion.

- Denture rebase procedures
- No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion. Denture reline procedures
  - No more than 1 time in any 36 months in a row. Only if more than 12 months have passed since the initial insertion.

- Other Type III Services
  - Diagnostic casts - No more than 1 time in any 36 months in a row. Only if required for extensive bilateral prosthetic dentistry other than dentures. Not a covered dental service if for orthodontic evaluation.

SPECIAL LIMITATIONS

Major Restorations

Covered Dental Expenses and covered dental services do not include, and we will not pay benefits for, the following:

- Inlays, onlays, crowns, cast restorations, veneers or other laboratory prepared

restorations:

- on teeth which may be restored with a direct placement filling material;
- in the absence of extensive decay or fracture;
- for loss of tooth structure due to attrition or abrasion; or
- for children under age 16 years, except for prefabricated stainless steel or prefabricated resin crowns on deciduous or primary teeth.

- The initial placement of a complete or partial denture unless:
  - it includes the replacement of a functioning natural tooth extracted while you or your Dependent are insured under the policy; and
  - that tooth cannot be added to an existing partial denture. We will not pay benefits for the initial placement of a complete or partial denture which replaces only those natural teeth missing on the date your or your dependents' insurance begins.

- The initial placement of a fixed partial denture unless:
  - it includes the replacement of a functioning natural tooth extracted while insured under the policy; and
  - that tooth was not an abutment to an existing fixed partial denture that is less than 7 years old (5 years old if a cast metal, resin bonded fixed retainer). Benefits for such initial placement are limited to benefits for the replacement of those functioning natural teeth which were extracted while you or your Dependent are insured under the policy and were not abutments to an existing fixed partial denture less than 7 years old (5 years if a cast metal, resin bonded fixed retainer). We will not pay benefits to replace natural teeth missing on the date that your or your Dependent's insurance begins.

- The replacement of inlays, onlays, crowns, core build-ups, cast restorations, or other laboratory prepared restorations unless:
  - at least 7 years have passed since the last placement (5 years for labial veneers, 3 years for prefabricated stainless steel or prefabricated resin crowns); and
  - they are not serviceable and cannot be restored to function.

- The replacement of a complete or partial denture, or the addition of teeth to a partial denture, unless:
  - replacement occurs at least 5 years after the initial date of insertion of the existing denture, provided the existing denture is not serviceable and cannot be restored to function; or
  - the addition of a tooth to a partial denture is required due to the dentally necessary extraction of a functioning natural tooth while you or your Dependent are insured under the policy; or
  - the replacement is made Dentally Necessary by an accidental non-chewing injury to a sound natural tooth, provided the replacement is completed within 12 months of the injury.

- The replacement of a fixed partial denture unless:
  - replacement occurs at least 7 years (5 years for a cast metal, resin bonded fixed retainer) after the initial date of insertion of the existing fixed partial denture, provided the exiting fixed partial denture is not serviceable and cannot be restored to function; or

  - replacement is required due to the Dentally Necessary extraction of a functioning natural tooth while you or your Dependent are insured under the policy, provided that the extracted tooth was not serving as an abutment to the existing fixed partial denture; or

  - replacement is made, provided the replacement Dentally Necessary by an accidental non-chewing injury to a sound natural tooth, is completed within 12 months of the injury.

- The replacement of an existing partial denture with fixed partial denture work unless upgrading to fixed partial denture work is essential to the correction of your or your Dependent's dental condition.

Coverage Under the Group's Medical Plan

If benefits for any covered dental expenses are provided under your employer's medical plan (if any), benefits otherwise payable for those expenses under the Policy will be reduced by the amount of benefits payable for those expenses under your employer's medical plan.

General Exclusions

Covered dental expenses and covered dental services do not include, and we will not pay benefits for, the following:

- The replacement of teeth beyond the normal complement.

- Appliances, inlays, onlays, crowns, or other cast or laboratory prepared restorations used primarily for the purpose of splinting.

- Facings on crowns or fixed partial dentures on molar teeth (which are always considered cosmetic under the Plan).

- Treatment which:
  - is not included in the list of covered dental services; or

  - has a date started before your or your Dependent's insurance begins; or

  - has a date started before any applicable waiting period has been served; or

  - has a date completed after your or your Dependent's insurance ends, except as may be specifically provided under Limited Extension of Benefits After Insurance Ends.

- Any Treatment, the sole or primary purpose of which relates to:
  - the charge or maintenance of vertical dimension; or

- ❍ the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or

- ❍ bite registration; or

- ❍ bite analysis.

- Any Treatment required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joints or its associated structures.

- Athletic mouthguards; replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; Treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.

- Treatment which:
  - ❍ is not Dentally Necessary; or

  - ❍ does not have uniform professional endorsement; or

  - ❍ is experimental or investigational in nature.

- Treatment which does not have a reasonably favorable prognosis.

- Treatment provided primarily for cosmetic purposes.

- Treatment received as a result of disease, defect, or Injury due to war or an act of war (declared or undeclared), taking part in a riot or insurrection, or committing or attempting to commit an assault or felony.

- Treatment of Injury arising out of, or in the course of, doing any work for pay, profit, or gain, whether on your or your Dependent's job or any other job.

- Treatment of an intentionally self-inflicted Injury.

- Treatment performed outside of the United States of America, other than Emergency Dental Treatment. However, for such Emergency Dental Treatment, the benefits payable shall not exceed the Allowable Charge for the Treatment at your employer's principal address (shown in the application for insurance) in the USA.

- Treatment rendered by a dental clinic or similar clinic that is operated by your or your Spouse's employer, labor union, or similar group.

- Treatment of a provider who is a member of your or your Spouse's Immediate Family.

- Treatment for which a charge would not have been made in the absence of insurance.

- Treatment for which you or your Covered Dependent do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

- Treatment that has not been both delivered to and accepted by you or your Covered Dependent.

- Orthodontic Treatment, unless such insurance is provided under the list of covered dental services.

SCHEDULE OF BENEFITS

Dental Insurance

Annual Deductible

Individual Deductible amount per Plan Year	$50

The Individual Deductible does not apply to Type I Dental Services

Coinsurance Percentages

	DENTAL SERVICES		
	TYPE I	TYPE II	TYPE III
COINSURANCE PERCENTAGE PER PERSON PER INDIVIDUAL BENEFIT YEAR	100%	80%	50%

Benefit Maximums:

Policy Year Maximum	$1500
DENTAL SERVICES	
All Services under Type I	No Waiting Periods
All Services under Type II	No Waiting Periods
All Services under Type III	No Waiting Periods

5. DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accidental Non-Chewing Injury shall mean an Injury (other than a chewing injury) sustained while insured under the Policy, which is caused solely and exclusively by an accident which could not be predicted in advanced, and which could not be avoided. A chewing injury is an Injury which occurs during the act of biting or chewing, regardless of whether the Injury is caused by biting or chewing food, biting on a foreign object not expected to be a normal constituent of food, parafunctional or abnormal habits such as (but not limited to) chewing on eyeglass frames or pencils, biting down on a suddenly dislodged or loose dental appliance, or biting or chewing on any other object for any other reason.

Allowable Expense(s) shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Appeal shall mean a formal review process requested after a claim for benefits is partially or completely denied.

Assignment of Benefits shall mean an arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less Deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and Deductibles, co-payments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole beneficiary.

Brand Name Drugs shall mean a drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer.

Calendar Year shall mean January 1st through December 31st of the same year.

Child(ren) shall mean a covered Employee's or covered Spouse's natural child, stepchild, a legally adopted child, a child placed for adoption, a foster child, a child for whom the covered Employee or covered Spouse is the legal guardian, or a child for whom health care coverage is

required through a Qualified Medical Child Support Order (QMCSO) or other court or administrative order.

Adult Children shall mean Children 19 years old through the limiting age of 26. The children and spouses of covered Adult Children are not eligible for coverage with the Plan.

Clean Claim shall mean a claim that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claim forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Co-Payment (Co-pay) shall mean a cost-sharing arrangement in which the Covered Person pays a specified flat amount for a specific service. It does not vary with the cost of the service.

Cosmetic Dentistry shall mean dentally unnecessary Surgical Procedures, usually but not limited to, plastic Surgery directed toward enhancing dental attractiveness.

Cosmetic or Cosmetic Surgery shall mean any Surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury.

Covered Expense(s) shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

Covered Person shall mean an Employee or Dependent who is covered by this Plan. A

Covered Employee may also be referred to as a participant. A Covered Dependent may also be referred to as a beneficiary.

Deductible shall mean the amount a Covered Person must pay each calendar year under the Plan, before benefits become payable. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

Dental Hygienist shall mean an individual who is licensed to practice dental hygiene and acting under the supervision of a Dentist within the scope of that license in treating the dental condition.

Dental Insurance shall mean the group dental insurance under the policy issued by us to the Policyholder.

Dentally Necessary and **Dental Necessity** shall mean a service or Treatment which is appropriate with the diagnosis and which is in accordance with accepted dental standards. The service or treatment must be essential for the care of the teeth and supporting tissues.

Dental Treatment Plan shall mean the Dentist's report of recommended Treatment which contains:

- a list of the charges and dental procedures required for the Dentally Necessary care;
- any supporting pre-operative x-rays; and
- any other appropriate diagnostic materials required by us.

Dentist shall mean a person who is properly trained and licensed to practice Dentistry and who is practicing within the scope of such license.

Denturist shall mean an individual who is licensed to make dentures and acting within the scope of that license in treating the dental condition.

Emergency Dental Treatment shall mean any Dentally Necessary service, procedure, or supply which is rendered as the direct result of unforeseen events or circumstances which require prompt attention.

Employee shall mean a person who the Participating Employer considers to be a common-law Employee and who is on the regular payroll of the Participating Employer for work performed, receiving W-2 wages. The term does not include individuals who perform services for the Employer through a leasing organization or entity/person who provides workers to others, leased Employees within the meaning of Section 414(n) of the Internal Revenue Code, individuals considered to be contract Employees, independent contractors or any other individual not receiving such W-2 wages and not considered to be a common-law Employee of a Participating Employer.

Employee Director shall mean a person who receives a percentage of their W-2 wages from a covered participating employer and a percentage of their W-2 wages from an appointed or designated eligible 501(c)(3) organization. Employee Directors are eligible to participate in the Plan with the same benefits and rights as Employees.

Enrollment Date shall mean the first day coverage is effective under the Plan. If coverage ends and later resumes, a new Enrollment Date begins. If the individual is eligible to enroll and

timely enrolls for coverage when eligible after initially satisfying the Employer's Waiting Period, the Enrollment Date is the first day of the Waiting Period.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the care and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Covered Person faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

Experimental Drugs shall mean drugs that are not commercially available for purchase and/or they are not approved by the U. S. Food and Drug Administration for general use.

Functioning Natural Tooth shall mean a Natural Tooth which is performing its normal role in the chewing process in the person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic replacement.

Family Unit shall mean the covered Employee and his/her family members who are covered as Dependents under the Plan.

Foster Child(ren) shall mean a Child for whom an Employee has assumed a legal obligation to support and care, provided:

1. Such Child normally lives with the Employee in a parent-child relationship; and
2. The Employee has a legal right to claim such Child as a Dependent on his Federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

Full-Time Active Permanent shall mean an Employee who is regularly scheduled to work at least 30 hours per week. Such term does not include seasonal, part-time Employees, volunteers, or independent contractors.

Generic Drug shall mean a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacists as being generic.

Genetic Information shall mean information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory test that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Hospital shall mean an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative Surgery on the premises.

The definition of “Hospital” shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Incurred shall mean the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Injury shall mean an accidental physical Injury to the body caused by unexpected external means.

Legal Guardian shall mean a person recognized by a court of law as having the duty of taking care of the person of and managing the property and rights of a minor child.

Maximum Allowable Charge shall mean the benefit payable for a specific coverage item or benefit under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

With respect to Non-Network Emergency Services, the Plan allowance is the greater of:

- The negotiated amount for In-Network Providers (the median amount if more than one amount to In-Network Providers).

- The Plan’s normal Non-Network payable amount after consideration of the criteria described below (reduced for cost-sharing).

- The amount that Medicare Parts A or B would pay (reduced for cost-sharing).

If and only if there is no negotiated rate for a given claim, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer’s retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator’s discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider

negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Medical Care Facility shall mean a Hospital, a facility that treats one or more specific ailments or any type of skilled Nursing/Extended Care Facility.

Medical Emergency shall mean a sudden onset of a condition with acute symptoms requiring immediate medical care and includes, but is not limited to, such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness, shortness of breath, convulsions or other such acute medical conditions.

Medical Care Necessity, Medically Necessary, Medical Necessity and similar language shall mean health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of that Covered Person's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Person's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person's Sickness or Injury without adversely affecting the Covered Person's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary".

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Natural Tooth shall mean any tooth or part of a tooth that is organic and formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Other Group Dental Expense Coverage shall mean:

- Any other group Policy providing benefits for dental expenses; or
- Any plan providing dental expense benefits (whether through a dental services organization or other party providing prepaid health or related services) which is arranged through any employer or through direct contact with persons eligible for that plan.

Out-of-Pocket shall mean the cost borne directly by Covered Person without the benefit of insurance, or additional out-of-pocket expenses, such as Deductibles, Co-payments, and Co-insurance.

Pharmacy shall mean a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Participating Employer shall mean each Employer whose Employees are eligible to be covered under the Plan.

Plan shall mean The Langdale Company Employee Benefit Plan, which is a welfare benefits Plan under ERISA for certain Employees of The Langdale Company and affiliated Participating Employers. The Plan is described in this document.

Plan Year shall mean the 12-month period on which the Plan's records are kept – i.e. January 1 through December 31.

Prescription Drug shall mean any of the following: Food and Drug Administration approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of Sickness or Injury.

Prior to Effective Date or After Termination Date shall mean dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Sound Tooth shall mean a Natural Tooth that is fully restored to function, does not have any decay, is not more susceptible to injury than a virgin tooth, and is without periodontal disease.

Special Enrollee shall mean a Covered Person who timely enrolls under the Plan during a HIPAA Special Enrollment or Change in Status Event as discussed under the Enrollment provisions of the Plan.

Spouse shall mean a person of the opposite sex to whom the Employee is married, and whose marriage has been licensed in accordance with the law of the jurisdiction in which the marriage occurred. The term "Spouse" will not include a person who asserts a spousal relationship pursuant to a common-law marriage. The Plan Administrator may require documentation providing such licensed relationship.

Subrogation shall mean the assumption by a third party (as a second creditor or an insurance company) of another's legal right to collect a debt or damages.

Substance Abuse shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition is applied as follows:

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
   1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect children or household);
   2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
   3. Craving or a strong desire or urge to use a substance;
   4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with Spouse about consequences of intoxication, physical fights);

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Surgical Procedures (or Surgery) shall mean any of the following:

- the incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- the manipulative reduction of a fracture or dislocation or the manipulation of a joint, including application of cast or traction;
- the removal by endoscopic means of a stone or other foreign object from any part of the body, or the diagnostic examination by endoscopic means of any part of the body;
- arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- obstetrical delivery and dilation and curettage;
- biopsy.

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

Total Disability (Totally Disabled) shall mean: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Treatment shall mean any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissues.

Waiting Period shall mean that period of time that an Employee must be employed in an Eligible Class of Employees prior to initial eligibility for coverage under the Plan. Each Participating Employer may establish their own separate Waiting Period for Eligible Class(es) of Employees and notify them accordingly.

6. PLAN EXCLUSIONS

Covered dental expenses and dental services do not include, and we will not pay benefits for, the following:

- **Additional Exclusions.** Replacement of mouth guards, replacement of lost or stolen appliances; myofunctional therapy; infection control; oral hygiene instruction; separate charges for acid etch; Treatment of jaw fractures; orthognathic surgery; personal supplies; broken appointments; completion of claim forms; exams required by a third party; travel time; transportation costs; professional advice given on the phone.
- **Alcohol.** Involving a Covered Person who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication, even if the cause of the Illness or Injury is not related to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This Exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

- **Any Treatment, the sole or primary purpose of which relates to:**
  - the change or maintenance of vertical dimension; or
  - the alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery (regardless of whether the periodontal surgery (regardless of whether the periodontal surgery itself is a covered dental service); or
  - bite registration; or
  - bite analysis

- **Cosmetic Treatment.** Treatment provided primarily for cosmetic purposes.

- **Dental Necessity.** Treatment which is not Dentally Necessary and/or does not have uniform professional endorsement.

- **Experimental and/or Investigational Treatment.** Treatment of an experimental or investigational nature.

- **Favorable Prognosis.** Treatment which does not have a reasonably favorable prognosis.

- **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government, or provided for by reason of the past or present services of any person in the armed forces of a government. This does not apply to Medicaid or when otherwise prohibited by Federal law.

- **Gratis Treatment.** Treatment for which you or your Covered Dependent do not have to pay, except when payment of such benefits is required by law and only to the extent required by law.

- **Illegal Acts.** That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

- **No Legal Obligation.** That are for services provided to a Covered Person for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Covered Person or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or the Plan, may be liable for necessitating the fees, care, supplies, or services.

- **No Dentist Recommendation.** Care, treatment, services or supplies not recommended and approved by a Dentist; or treatment, services, supplies when the Covered Person is not under the regular care of a Dentist. Regular care means ongoing dental supervision or treatment which is appropriate care for the Injury or Sickness.

- **Non-Specified Services.** Services, treatments and supplies which are not specified as covered under this Plan.

- **Occupational.** For any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit; If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

- **Orthodontic Treatment.** Orthodontic Treatment unless such insurance is provided under the list of covered dental services.

- **Pain Control Devices.** Charges for implanted devices for control of pain in excess of one device, internal battery replacement and/or implantation per Calendar Year.

- **Plan Design Excludes.** Charges excluded by the Plan design as mentioned in this document.

- **Postage, Shipping, Handling Charges, Etc.** That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

- **Prior to Coverage.** This Plan does not cover any charge for care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

- **Professional (and Semi-Professional) Athletics (Injury/Illness).** That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

- **Prohibited by Law.** To the extent that payment under this Plan is prohibited by law, such services are not covered.

- **Provider Error.** That are required as a result of unreasonable Provider error.

- **Provider Negligence.** No benefits are payable in connection with expenses resulting from or associated with: (a) the unintended retention of a foreign object in a patient following an invasive procedure, (b) errors involving the use/administration of medications, gases, intravenous fluids and/or biological drugs, including the use of contaminated or expired substances, (c) a hemolytic reaction due to the administration of ABO/HLA-incompatible blood or blood products or tissue, (d) injuries acquired following admission to a health care facility, unless resulting entirely from the patient's own negligence or while intending to do harm to himself/herself, (e) surgery performed on the wrong patient or body part, or performance of the wrong surgical procedure, (f) burns or Stage 3 or 4 pressure ulcers acquired following admission to a health care facility, (g) expenses relating to the repair or replacement of a defective implant/device, or (h) intravascular air embolism or blockage, catheter-associated urinary tract infection or vascular catheter-associated infection.

- **Relative Giving Services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

- **Self-Inflicted Injury.** Any treatment of an intentionally self-inflicted Injury. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions). However, if a member is participating in a high risk activity, the Plan may exclude benefits.

- **Services Before or After Coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

- **Subrogation, Reimbursement, and/or Third Party Responsibility.** This Plan does not cover any charge for care, supplies, treatment, and/or services that of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

- **TMJ.** Any Treatment required directly or indirectly to diagnose or treat a muscular, neural, or skeletal disorder, dysfunction, or disease of the temporomandibular joint or its associated structures.

- **Travel or Accommodations.** Charges for travel or for travel outside the United States or its territories or accommodations, for services or supplies, whether or not recommended by a Physician. Travel by ambulance is covered as stated in this Plan within the United States. Accommodations in select U.S. areas are covered under the Plan with prior approval from the Plan Administrator.

- **Treatment** rendered by a dental clinic or similar clinic that is operated by your or your Spouse's employer, labor union, or similar group.

- **Treatment** for which a charge would not have been made in the absence of insurance.

- **Treatment Outside United States.** Any treatment performed outside of the United States of America, other than Emergency Dental Treatment. However, for such Emergency Dental Treatment, the benefits payable shall not exceed the Allowable Charge for the Treatment at your employer's principal address (shown in the application for insurance) in the USA.

- **Undelivered Treatment.** Treatment that has not been both delivered to and accepted by you or your Dependent.

- **War/Riot.** That incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

The exclusions listed above, as well as all the terms of the Plan, shall be interpreted in accordance with the laws that govern the Plan. With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

7. CLAIMS AND APPEALS

A Covered Person becomes a “claimant” when he or she makes a request for a Plan benefit(s) in accordance with these claims procedures. These procedures describe how benefit claims and appeals are made and decided under the Plan, and applicable timelines. All claims must be received by the Plan Administrator within 120 days from date of service.

CLAIMS FOR BENEFITS

Three Claim Types
As described below, there are three categories of claims that can be made under the Plan, each with somewhat different claim and appeal rules. The DOL regulations set different requirements based on the type of claim involved. The primary difference is the timeframe within which claims and appeals must be determined. It is very important to follow the requirements that apply to your particular type of claim. If you have any questions regarding what type of claim and/or what claims procedure to follow, please contact the Plan Administrator.

Under the Plan, there are three types of claims:
- Pre-service Non-urgent
- Concurrent Care
- Post-service

Pre-service Non-urgent Care Claims
A "Pre-service Non-urgent Care Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on receiving approval of the benefit in advance of obtaining dental care. This claim does not involve urgent care because there is not a serious jeopardy to the life or health of the claimant, and severe pain is not involved. (See definition of "’Urgent Care Claim" below.)

An “Urgent Care Claim" is any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. **It is important to remember that, if a claimant needs dental care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The claimant should obtain such care without delay.**

Further, since the Plan does not require the claimant to obtain approval of a dental service prior to getting treatment in an urgent care situation, there are no Pre-service Urgent Care Claims under the Plan. The claimant simply follows the Plan’s procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims
A “Concurrent Claim” arises when the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the claimant requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the claimant to obtain approval of a dental service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims
A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

How To File A Claim
A Pre-service Non-Urgent Care Claim (including a Concurrent Claim that also is a Pre-service Non-Urgent Care Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Plan Administrator.

A Post-service Claim is considered to be filed when the information required of claims (listed below) is received in writing by the Plan Administrator.

For Plan reimbursements, submit bills for service rendered.

ALL BILLS AND CLAIMS MUST BE RECEIVED BY THE PLAN ADMINISTRATOR **WITHIN 120 DAYS** FROM DATE OF SERVICE.

ALL BILLS AND CLAIMS MUST SHOW:

- Name of Plan
- Group number of Plan
- Employee's name
- Name of claimant
- Name, address, telephone number and Tax ID of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of service
- Charges

Send the above via U.S. Postal Service to the Plan Administrator, within 120 days from date of service to this address:

TLC Benefits Solutions, Inc. (Plan Administrator)
P.O. Box 947 Valdosta, GA 31603-0947
229-249-0940 or 877-949-0940

Upon receipt of this information, the claim will be deemed to be filed with the Plan. All questions about how to file a claim should be directed to the Plan Administrator.

Incorrectly Filed Claims

These claims procedures do not apply to any request for benefits that is not made in accordance with these claims procedures, except that (a) in the case of an incorrectly filed Pre-service Non-urgent Claim, the claimant shall be notified as soon as possible but no later than 5 days following receipt by the Plan of the incorrectly filed claim. The notice will describe the proper procedures for

filing a claim. This notice may be given verbally unless written notice is specifically requested by the claimant.

Appointment of Authorized Representative

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

Timing of Claim Decisions

Pre-service Non-urgent Care Claims

- A determination will be made in a reasonable period of time appropriate to the circumstances, but not later than 15 days after receipt of the claim.

Concurrent Claims

- Plan Notice of Reduction or Termination. If the Plan has determined that an initially approved course of treatment should be reduced or terminated (other than by Plan amendment or Plan termination), this will be treated as an adverse benefit determination, and the claimant will be notified sufficiently in advance to allow the claimant to appeal the decision before the care is reduced or terminated.

- Request by Claimant Involving Non-urgent Care. If the claimant has requested that the Plan extend an initially approved course of treatment beyond the period of time or number of treatments that has been approved, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

- A determination will be made within a reasonable period of time, but not later than 30 days after receipt of the claim.

Extensions of Time

Despite the specified timeframes, nothing prevents the claimant from voluntarily agreeing to extend the above timeframes.

In addition, if the Plan is not able to decide a pre-service or post-service claim within the above timeframes due to matters beyond its control, one 15-day extension of the applicable timeframe is permitted, provided that the claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected.

If an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be given 45 days from receipt of the notice within which to provide the information requested. The period of time for deciding the claim will be tolled from the date on which the notification of the extension is sent to the claimant, until the date on which the claimant timely responds to the request for information. If the requested information is not provided, the claim may be decided without that information.

Calculating Time Periods

The period of time within which a benefit determination will be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Adverse Benefit Determination

An "adverse benefit determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on:

- A determination of an individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; or
- A determination that a benefit is experimental, investigational, or not Dentally Necessary or appropriate.

Although it is not a claim for benefits, the definition of an adverse benefit determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. Notice of an adverse benefit determination for a rescission will be sent 30 days in advance of the retroactive termination of coverage.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a claimant with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. The date of service, the dental provider, the claim amount (if applicable), denial code and its corresponding meaning, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. Any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and
6. In the case of denials based upon a medical judgment (such as whether the treatment is Dentally Necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's dental circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.
7. The contact information for the Department of Labor's Employee Benefits Security Administration and any applicable state consumer assistance program.

INTERNAL APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims

Pursuant to the Department of Labor (DOL) regulations, the Plan's claims and appeals procedures provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination.

First Internal Appeal Level

Requirements for First Appeal

The claimant must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. (The 180-day period is reduced to 30 days if appealing the Plan's decision to reduce or terminate a previously approved ongoing course of treatment before the end of the approved period of time or number of treatments.) To file an appeal in writing, the claimant's appeal must be addressed to the Plan Administrator and mailed as follows:

TLC Benefits Solutions, Inc.
P. O. Box 947
Valdosta, GA 31603-0947
229-249-0940 or 877-949-0940

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the claimant;
2. The claimant's address and telephone number
3. The group name or group identification number;
4. All facts, theories, and documents supporting the claim for benefits. Failure to include any facts, theories, or supporting documentation in the written appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise arguments which support his claim if he fails to include them in the written appeal;
5. A statement in clear and concise terms of why the claimant disagrees with the reason(s) given for denying the claim or with the prior handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

Review of Adverse Benefit Determination on First Appeal

The first appeal of an adverse benefit determination will be reviewed and decided by the Plan Administrator. The person who reviews and decides an appeal will be a different individual than the person who made the initial benefit decision and will not be a subordinate of the person who made the initial benefit decision. The review by the Plan Administrator will take into account all information submitted by the claimant, whether or not presented or available at the initial benefit decision. The Plan Administrator will give no deference to the initial benefit decision.

Consultation With Expert

In the case of a claim denied on the grounds of a medical judgment, the Plan Administrator will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial benefit decision or a subordinate of that individual.

Access to Relevant Information and Rationale
A claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. If the advice of a dental or vocational expert was obtained in connection with the initial benefit decision, the names of each such expert shall be provided on request by the claimant, regardless of whether the advice was relied on by the Plan. Before issuing a final decision on appeal that is based on a rationale that was not included in the initial determination, the Plan will provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance ofthe final internal adverse benefit determination to give the claimant a reasonable opportunity to respond.

Timing of Notification of Benefit Determination on First Appeal
The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the dental circumstances, but not later than 15 days after receipt of the appeal.

Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim - Pre-service Non-urgent or Post-service.

Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on First Appeal. The Plan Administrator shall provide a claimant with notification, with respect to all types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The date of service, the healthcare provider, the claim amount (if applicable), denial code and its corresponding meaning, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;
3. The identity of any dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying

the terms of the Plan to the claimant's dental circumstances, will be provided free of charge upon request;

7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. A description of available internal appeals processes;
10. The contact information for any applicable health insurance consumer assistance or ombudsman;
11. A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
12. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

SECOND AND FINAL INTERNAL APPEAL LEVEL

Adverse Decision on First Internal Appeal; Requirements for Second and Final Internal Appeal

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

TLC Benefit Solutions, Inc.
P. O. Box 947
Valdosta, GA 31603-0947

The second appeal of an adverse benefit determination will be reviewed and decided by the Plan Administrator.

Timing of Notification of Benefit Determination on Second and Final Internal Appeal

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims. Within a reasonable period of time appropriate to the dental circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Claims. The response will be made in the appropriate time period based upon the type of claim - Pre-service Non-urgent or Post-service.

Post-service Claims. Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

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

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

The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal." The Plan must include a discussion of the reason(s) for the final internal adverse benefit determination.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

The Plan must provide, free of charge, any new or additional evidence considered, relied upon, or generated in connection with a claim sufficiently in advance of a final internal adverse benefit determination to give the claimant opportunity to respond prior to the deadline. In addition, before the Plan can base a final internal adverse benefit determination on new or additional rationale, it must provide the claimant with such rationale sufficiently in advance of deadline to allow the enrollee an opportunity to respond.

Decision on Second and Final Internal Appeal

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision on second and final internal appeal is final, except to the extent that other remedies are available under State and or Federal law.

CONTINUED COVERAGE PENDING APPEAL

The claimant’s coverage will continue pending the outcome of an appeal, except when appeal is pursuant to a rescission of coverage.

PROVIDER OF SERVICE APPEAL RIGHTS

Covered Person may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a Covered Person to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an internal appeal received from the provider in the same manner as a claimant's internal appeal and will respond to the provider and the claimant with the results of the internal review accordingly. Any such appeal from a provider of service must be made with- in the time limits and under the conditions for filing an internal appeal specified under Section 7: Claims and Appeals, above. Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for covered dental expenses directly from the Plan, waiving any right to recover such expenses from the claimant, and comply with the conditions of the section, "Requirements for Appeal", above.

Also, for purposes of this section, if a provider indicates on a ADA Dental Form (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Plan Administrator for additional information regarding provider of service appeals.

LIMITATION OF ACTION

You must exhaust the appeals process before bringing a lawsuit for judicial review. Further, any legal action for judicial review must be brought within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action.

ASSIGNMENTS

Assignment by a Claimant to the Provider of the Claimant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Claimant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Claimant shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Claimant, has been received.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Network Provider will be considered "assigned" to such Provider and will be paid directly to such Provider, whether or not a written Assignment of Benefits was executed. Notwithstanding any assignment or non-Assignment of Benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be

payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of Benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If Assignment of Benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

8. COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Allowable Expenses when two or more plans – including Medicare – cover an individual. When a Covered Person is covered by this Plan and one or more other plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will coordinate coverage (i.e. may be entitled to reduce benefits payable under the secondary/subsequent plans by the amount paid by the primary plan(s)).

WHEN THIS PLAN IS SECONDARY COVERAGE

This Plan contains a non-profit provision integrating it with other similar plans under which an individual may be covered so that the total benefits available during the Calendar Year will not exceed the benefits of this Plan that would have been provided in the absence of Coordination of Benefits.

If, in the integration method of determining the benefits of this Plan with those of another plan, the rules set forth in the following Benefit Plan Payment Order paragraph would require this Plan to be the secondary payer, then the Plan shall determine its Allowable Expense without regard to the existence of other coverage; however, the Plan shall pay the lesser of (1) the Plan's Allowable Expense minus the amount paid by the primary plan and (2) the primary plan's allowable expense minus the amount paid by the primary plan.

Covered Persons for whom the Plan is secondary coverage under these rules, not primary coverage, must file all dental expenses with the primary payer initially, and then provide an Explanation of Benefits (EOB) to the Plan Administrator.

BENEFIT PLAN

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

(1) Group or group-type plans, including franchise or blanket benefit plans, whether or not insured.

(2) Blue Cross and Blue Shield group plans.

(3) Group or group-type coverage through HMOs, and other prepayment, group practice and individual practice plans.

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

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

(6) The dental benefits coverage in group, group-type, and individual no fault auto insurance, uninsured coverage, and underinsured motorist coverage, by whatever names they are called.

EXCESS INSURANCE

If at the time of injury, sickness, disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

a) any primary payer besides the Plan;
b) any first party insurance through dental payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker's compensation or other liability insurance company; or
e) any other source, including but not limited to any crime victim restitution funds, medical, dental, disability or other benefit payments, and school insurance coverage.

VEHICLE LIMITATION

When medical/dental payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of dental payments under vehicle plans and/or policies regardless of its name, title or classification.

ALLOWABLE EXPENSE(S)

Shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

BENEFIT PLAN PAYMENT ORDER

When two or more plans provide benefits for the same Allowable Expense, benefit payment will follow these rules:

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

(2) Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Expense:

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

Special Rule: If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

(b) The benefits of a plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan providing non-continuation coverage is primary and the plan providing continuation coverage is secondary.

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

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

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

(e) When a child's parents are divorced, not married, or legally separated (whether or not they were ever married), these rules will apply:

(i) The plan of the parent with custody will be considered first
(ii) The plan of the Spouse of the parent with the custody of the child will be considered second.
(iii) The plan of the parent not having custody of the child will be considered third.
(iv) The plan of the Spouse of the parent without custody will be considered next.
(v) This rule will be in place of items (i) through (iv) above when it applies. A court decree may state which parent is primarily responsible for dental benefits of the child. In this case, and if the plan of that parent has

knowledge of the terms of the decree, the plan of that parent will be determined first. The plan of the other parent shall be the secondary plan. This paragraph does not apply with respect to any claim determination period during which any benefits are actually paid or provided before the entity has that actual knowledge.

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

(f) If none of the above rules determines the order of benefits, the benefits of the plan which covered the person for the longer period of time is primary.

(3) Medicare will pay primary, secondary or last to the extent stated in Federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on information available through CMS.

This Plan will be primary to Medicare as may be required, if the Medicare eligibility is based solely upon the diagnosis of End Stage Renal Disease (ESRD). Afterwards, Medicare will become the primary payer of benefits.

This Plan will pay primary to Medicare only as required by the Medicare Secondary Payer rules. Nothing herein shall be construed as providing for a longer period during which this Plan will be primary.

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

CLAIMS DETERMINATION PERIOD

Benefits will be coordinated on a Plan year basis (i.e. January 1 through December 31). This is called the claim determination period.

RIGHT TO RECEIVE OR RELEASE NECESSARY INFORMATION

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Expenses.

FACILITY OF PAYMENT

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan, and the Plan will not pay that amount again.

RIGHT OF RECOVERY

In accordance with Section 16: Recovery of Payments of this SPD, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess. Please see Section 9: Recovery of Payments for more details.

MEDICAID COVERAGE

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits which are payable under the Plan.

9. RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan ("Erroneous Payments"). As a result, the Plan may pay benefits that are later found to be greater than the Maximum Allowed Amount.

In such cases, the Plan has the right to recover the amount of any Erroneous Payment directly from the person or entity who received such payment, from other payers, and/or from the Employee or Dependent on whose behalf such payment was made.

The Plan has the right to recover benefits it has paid on an Employee's or Dependent's behalf that were:

a. made in error;
b. due to a mistake or misstatement in fact;
c. due to fraud or misrepresentation;
d. in anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions;
e. pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Recipients of Erroneous Payments shall return or refund the amount of such Erroneous Payment to the Plan within 30 days of discovery or demand. Recipients include a covered Employee, Dependent, dental provider, another benefit plan, insurer or any other person or entity who receives an Erroneous Payment exceeding the amount of benefits payable under the terms of the Plan.

The person or entity receiving an Erroneous Payment may not apply such payment to another expense. The Plan Administrator shall have no obligation to secure payment for the expense for which the Erroneous Payment was made or to which it was applied.

The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an Erroneous Payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor, to the extent permitted by law. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ADA standards, Medicare guidelines,

or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand. Any Erroneous Payments not repaid within 30 days of discovery or demand shall incur pre- judgment interest of 1.5% per month.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Further, Employees, Dependents, and/or their beneficiaries, estate, heirs, guardian, personal representative, or assigns shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

If the Plan must bring an action against an Employee, Dependent, provider or other per- son or entity to enforce the provisions of this section, then that, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

10. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PAYMENT CONDITION

This section explains how your benefits are impacted if you suffer a Sickness or Injury that is caused by and/or payable by a third party other than the Plan.

For example, if a third party is responsible for payment for a Sickness or Injury for which you receive a settlement, judgment, insurance proceeds, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that Sickness or Injury. You must reimburse the Plan even if you have not been “made whole” for your Sickness or Injury.

Please contact the Plan Administrator if you have any questions regarding this section.

A. CONDITIONAL PAYMENT OF BENEFITS

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan’s right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan

out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

B. SUBROGATION

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

   a. The responsible party, its insurer, or any other source on behalf of that party,
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage,
   c. Any policy of insurance from any insurance company or guarantor of a third party,
   d. Workers ' compensation or other liability insurance company,
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

   then the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s)

assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. RIGHT OF REIMBURSEMENT

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person(s) obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

D. COVERED PERSON IS A TRUSTEE OVER PLAN ASSETS

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising

from any injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:

a. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
c. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

E. RELEASE OF LIABILITY

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) ("Incurred") prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be incurred, and for which the Plan will be asked to pay.

F. EXCESS INSURANCE

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's *Coordination of Benefits* section. The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Worker's compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

G. SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

H. WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

I. OBLIGATIONS

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

   a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

   b) To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

   c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

   d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

   e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

   f) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.

   g) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

   h) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

   i) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

j) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.

k) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses, including any attorney's fees incurred, associated with the Plan's attempt to recover such money from the Covered Person(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

J. OFFSET

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

K. MINOR STATUS

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

L. LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

M. SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

11. COBRA CONTINUATION OPTIONS

INTRODUCTION

If you lose your Plan coverage, you may have the right to temporarily extend it under the federal law Consolidated Budget Reconciliation Act of 1985 (COBRA).

This section generally explains COBRA continuation coverage, when COBRA coverage may become available to you and your family, and what you need to do to protect the right to receive it. Please read this information carefully. The Plan offers no greater COBRA rights than what the COBRA statute requires. You should contact your Plan Administrator if you have questions about your right to continue coverage.

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when that coverage would otherwise end because of certain events called "qualifying events." Specific qualifying events are listed below. After a qualifying event occurs and any required notice of that event is properly given, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

The word "you" below generally refers to each person covered by the Plan who is or may become a qualified beneficiary.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

WHAT ARE QUALIFYING EVENTS?

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of one of the following qualifying events:

(1) Your hours of employment are reduced; or

(2) Your employment ends for any reason (other than your gross misconduct).

If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason (other than for gross misconduct); or

(4) You become divorced or legally separated from your spouse; or

(5) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

If you are the dependent child of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because of any of the following qualifying events:

(1) Your parent-employee dies;

(2) Your parent-employee's hours of employment are reduced;

(3) Your parent-employee's employment ends for any reason (other than for gross misconduct);

(4) Your parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(5) Your parents become divorced or legally separated; or

(6) You no longer meet the Plan's definition of a dependent child and are therefore no longer eligible.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has received proper notice that a qualifying event has occurred. When the qualifying event is the end of employment , the reduction of hours of employment, the death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your employer will give the required notice to the Plan Administrator.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator **in writing within 60 days** after the later of the qualifying event at the following address:

Plan Administrator - TLC Benefit Solutions, Inc.
P. O. Box 947
Valdosta, GA 31603
Tel: (229) 249-0940
Toll Free: (877) 949-0940

You will need to provide a copy of court orders or any other paperwork that is needed in order to determine COBRA eligibility.

Notice can be given by the covered employee, by a qualified beneficiary, or by a representative of either.

If you send a notice through the mail, the notice must be post-marked within the 60-day period described above. **If your notice is not properly and timely given, you will lose your right to elect COBRA.**

ELECTING COBRA COVERAGE

Once the Plan Administrator receives notice and satisfactory proof that a qualifying event has occurred, COBRA coverage will be offered to each qualified beneficiary. At that time, you will receive information about the cost of COBRA coverage, and how to elect and pay for COBRA. **To elect COBRA, you must complete the election form that will be provided to you and timely return the form within a 60-day election period.**

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

ELECTING COBRA AFTER LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the Plan Administrator for more information about these special rules.

SPECIAL RULES FOR FEDERAL TRADE ADJUSTMENT ASSISTANCE

The Trade Adjustment Assistance Act of 2002 amended COBRA to provide certain trade affected workers with a second opportunity to elect COBRA continuation coverage. Individuals who are eligible for trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) and who did not elect COBRA during the general election period may get a second election period. This additional, second election period is measured 60 days from the first day of the month in which an individual is determined TAA-eligible.

For example, if an individual's general election period runs out and he or she is determined TAA-eligible 61 days after separating from employment, at the beginning of the month, he or she would have approximately 60 more days to elect COBRA. However, if this same individual is not

determined TAA-eligible until the end of the month, the 60 days are still measured from the first of the month, in effect giving the individual about 30 days.

Additionally, the Trade Act of 2002 added another limit on the second election period. A COBRA election must be made not later than 6 months after the date of the TAA-related loss of coverage. COBRA coverage chosen during the second election period typically begins on the first day of that period.

More information about the Trade Act is available at www.doleta.gov/tradeact.

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay for the entire cost of COBRA coverage, plus an administrative fee. The amount may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to disability, 150 percent) of the cost of the Plan (including both employer and employee contributions) for coverage of a similarly situated Covered Person or beneficiary who is not receiving COBRA coverage. You will be notified of the cost in your COBRA election materials. The amount of your COBRA premiums may change from time to time as the law allows and will most likely increase over time.

PAYING FOR COBRA COVERAGE

You must make your first payment for COBRA coverage no later than 45 days after the date you elect COBRA. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the time you make the first payment. **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your COBRA election, you will lose all COBRA rights under the Plan.**

Monthly payments for each subsequent month of coverage are due on the first day of the month for that month's COBRA coverage, subject to a 30-day grace period. **If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage.**

If you have questions regarding paying for COBRA coverage, please contact the Plan Administrator.

HOW LONG DOES COBRA COVERAGE LAST?

As explained above, COBRA coverage is a temporary continuation of Plan coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment

terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage can be extended. Please contact the Plan Administrator for Plan procedures and applicable deadlines governing requests for COBRA extensions.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you provide timely written notice to the Plan Administrator, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if you provide timely written notice to the Plan Administrator within 60 days of the second qualifying event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

OTHER INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child who is born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary if the covered employee has elected COBRA coverage for himself or herself. Continuation coverage may be elected for the child, provided the child satisfies the otherwise applicable plan eligibility and enrollment requirements, and provided that timely notice of the birth or adoption is given under the applicable terms of the Plan. If timely notice is not given, the child cannot be added to COBRA continuation coverage. The child's COBRA coverage begins when the child begins participation in the Plan, and it lasts for as long as COBRA lasts for other similarly situated qualified beneficiaries in the family.

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

The coverage periods described above are maximum coverage periods. COBRA coverage will terminate before the end of the maximum coverage if:

(1) Any required premium is not paid in full and on time;

(2) The qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both), after electing COBRA (you should provide notice if Medicare entitlement occurs);

(3) The employer ceases to provide any group health plan for its employees; or

(4) In the case of a disability extension, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled (you should provide notice if the Social Security Administration makes this determination).

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

COVERAGE OPTIONS OTHER THAN COBRA

There may be coverage options other than COBRA for you and your family. Under PPACA, health coverage is available through the Health Insurance Marketplace. In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

IF YOU HAVE QUESTIONS

Questions about your rights under COBRA, and other questions about the Plan, can be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. Updates should be provided to the Plan Administrator. You should also keep for your records a copy of any notices and other communications you send to the Plan Administrator regarding COBRA.

12. OTHER FEDERAL LAWS THAT APPLY

The Plan is a welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). The Plan is also a non-grandfathered health plan subject to the requirements of the Patient Protection and Affordable Care Act (PPACA). Other federal laws also govern the Plan, which are briefly summarized below. For more information, please contact the Plan Administrator.

HIPAA Privacy & Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your protected health information.

The Langdale Company Employee Benefit Plan (the "Plan") will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operations, Plan administration, or as required or permitted by law.

A description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules is set forth in the Plan's Notice of Privacy Practices ("Privacy Notice"), which is furnished to all Covered Persons at the time of enrollment, is available upon written request, and can also be accessed on the Plan's internet site at: **www.tlcbenefitsolutions.net**.

Privacy Officer And Contact Person

The HIPAA Privacy and Security Officer for the Plan, whose responsibility is the development and implementation of policies and procedures to ensure compliance with HIPAA, shall be the individual whose job title is "Privacy Officer." The contact person or office responsible for receiving complaints regarding health information privacy, and who is able to give further information concerning matters covered by the Privacy Notice, is the Privacy Officer.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits the Plan from:

- Requesting or requiring individuals or their family members to undergo genetic testing.
- Using genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collecting genetic information for underwriting purposes or with respect to any individual prior to enrollment or coverage.
- Adjusting group premium or contribution amounts on the basis of genetic information.

The Plan will not discriminate in individual eligibility, benefits or premiums based on any genetic information. The Plan will not require genetic testing of Covered Persons or intentionally gather genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

What is "genetic information"?

Genetic information means information about an individual's genetic tests, the genetic tests of family members of the individual, family medical history or any request for and receipt of genetic services by an individual or a family member. The term also includes, with respect to a pregnant woman (or a family member of a pregnant woman) genetic information about the fetus and with respect to an individual using assisted reproductive technology, genetic information about the embryo.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Covered Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and his/her Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

Plan coverage may be continued under USERRA for up to the lesser of:

(1) The 24-month period beginning on the date on which the Employee's absence begins; or

(2) The day after the date on which the Employee fails to apply for or return to a position of employment, as required by USERRA.

An Employee who elects to continue coverage under USERRA may be required to pay not more than 102 percent of the full premium under the Plan (determined in the same manner as the applicable COBRA premium) associated with such coverage for other Employees. In the case of an Employee who performs service in the uniformed services for less than 31 days, such Employee may not be required to pay more than the Employee's share, if any, for such Plan coverage.

To the extent allowed by law, COBRA coverage and USERRA coverage run concurrently.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible Dependents in Plan coverage immediately upon returning to active employment, even if you and your dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting period.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

13. PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The Plan is administered by TLC Benefit Solutions, Inc. ("Plan Administrator"). The Plan Administrator shall have the full power and discretionary authority to control and manage all aspects of the Plan in accordance with its terms and all applicable laws, including, but not limited to:

- Administer the Plan according to its terms and to interpret Plan policies and procedures;
- Interpret terms of the Plan and determine eligibility for participation and for benefits under the Plan;
- To make factual and legal findings;
- Resolve and clarify inconsistencies, ambiguities and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

Statements

All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole

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

Binding Arbitration

Note*: You are enrolled in a plan provided by your Employer that is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA's claims procedure rules and is not subject to mandatory binding arbitration. You may pursue voluntary binding arbitration after you have completed an appeal under ERISA. If you have any other dispute which does not involve an adverse benefit decision, this Binding Arbitration provision applies.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA, and any other applicable State law(s).

14. GENERAL PLAN INFORMATION

PLAN NAME: The Langdale Company Employee Benefit Plan

PLAN NUMBER: 502

PLAN SPONSOR'S TAX ID NUMBER: 58-0542427

PLAN TYPE: Welfare Benefits Plan (Group Health Plan)

PLAN YEAR: January 1 – December 31

PLAN ADMINISTRATION: Self-funded

SOURCE OF BENEFITS: General assets of Participating Employers

SOURCE OF CONTRIBUTIONS: Employee and Participating Employers

PLAN EFFECTIVE DATE: November 5, 1990

PLAN SPONSOR INFORMATION:

The Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601
Phone: (229) 333-2500

PLAN ADMINISTRATOR:

TLC Benefit Solutions, Inc.
P. O. Box 947
Valdosta, Georgia 31603
Phone: (229) 249-0940
Toll Free: (877) 949-0940

AGENT FOR SERVICE OF LEGAL PROCESS:

Vice President of Human Resources The
Langdale Company
1202 Madison Highway
Valdosta, Georgia 31601

Service of legal process may also be made on the Plan Administrator - TLC Benefit Solutions, Inc.

PARTICIPATING EMPLOYERS WHOSE EMPLOYEES MAY BE COVERED:

CBC Capital, Inc. d.b.a. Fussell Tire & Service
Industrial Cutting Tools, Inc.
Kinderlou Forest Development, LLC
Kinderlou Forest Golf Club, LLC
LANCO Trucking, Inc.
Langboard, Inc.
Langdale Chevrolet, Inc.
The Langdale Company
Langdale Farms LLC
Langdale Forest Products Co.
Langdale Fuel Co.
Langdale Industries, Inc.
Langdale Powersports, LLC
Langdale Timber Company
Langdale Woodlands, LLC
Lowndes Bancshares, Inc., d.b.a. Commercial Banking Company
Naval Stores Suppliers, Inc., d.b.a. Southern Builders Supply Co.
Southland Forest Products, Inc.
TLC Benefit Solutions, Inc.
TLC Building Components, Inc.
TLC Mouldings, Inc.
TLC Wood Additives
The Val d'Aosta Company, d.b.a. Kinderlou Inn

Amendment or Termination of the Plan

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan, in whole or in part, for any reason. Only the Plan Sponsor has the authority to amend or terminate the Plan. Such authority of the Plan Sponsor may be exercised by the Vice President of Human Resources after consultation with the President and upon approval of the President. All amendments will be made via a written instrument signed by the Plan Sponsor. The Vice President of Human Resources may sign such amendment.

Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Rescission of Coverage for Misrepresentation or Fraud

Rescission is the cancellation or discontinuance of coverage under the Plan that has retroactive effect.

The Plan will rescind Plan coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact in connection with eligibility for coverage, a claim for benefits, enrollment information, or any other matter affecting a Covered Person's receipt of Plan coverage or benefits.

With respect to eligibility, when you enroll a Spouse or Child in the Plan, you represent the following—

- The Spouse or Child is eligible under the terms of the plan; and
- You will provide evidence of eligibility on request;

Further, you understand that—

- The plan is relying on your representation of eligibility in accepting the enrollment of your Spouse and Children;
- Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and
- Your failure to provide evidence of eligibility will result in disenrollment of the Spouse and/or Child, which may be retroactive to the date as of which the Spouse and/or Child became ineligible for plan coverage, as determined by the Plan Administrator.

Conformity to Law

This Plan shall be interpreted to comply with the requirements, to the extent required, of any applicable law or regulation to which it is subject, including but not limited to, the Employment Retirement Income Security Act (ERISA), and the Internal Revenue Code (IRC).

Clerical Error

Any clerical error by a Participating Employer, the Plan Administrator, or an agent of either, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. The Plan reserves the right to recover any overpayments, as described in the Recovery of Payments section of this SPD.

15. STATEMENT OF ERISA RIGHTS

As a Covered Person in The Langdale Company Employee Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at your Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance con- tracts, if any, and a copy of the latest annual report (Form 5500 Series), if a report is required, that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Upon written request to the Plan Administrator, obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series), if a report is required, and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Plan Coverage

Continue group health plan 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 must pay for such coverage. Please refer to Section 11: COBRA Continuation Options and the documents governing the Plan's rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the persons who are responsible for the operation of the Plan. These persons are referred to as "fiduciaries." 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 Covered Persons and beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents (without charge) relating to the decision, and to appeal any denial, all within certain time schedules. Please see **Section 7: Claims and Appeals** for more details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case the court may require the Plan Administrator to provide the materials and to pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims and appeal procedures that are available to you under the Plan, you may file suit 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 (if the Plan is considered to have 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. However, no legal action may be commenced or maintained against the Plan prior to your exhaustion of the Plan's claims procedures described in **Section 7: Claims and Appeals**.

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 (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, 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 (EBSA).

P.O. Box 947 ▪ Valdosta, GA 31603
(229) 249-0940 or (877) 949-0940