PLAN DOCUMENT
AND SUMMARY PLAN DESCRIPTION

DIOCESE OF YAKIMA
DENTAL CARE BENEFITS PLAN

EFFECTIVE NOVEMBER 1, 2020

TPSC GROUP # 46270

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DENTAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATIONS	Services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
ANNUAL MAXIMUM BENEFIT *Excludes Class I Diagnostic & Preventive Services.*	**$1,500** Individual per Calendar Year
DEDUCTIBLE	**$50** Individual; **$150** Family per Calendar Year

DENTAL BENEFITS		
CLASS I **Diagnostic & Preventive Services**	**CLASS II** **Basic Services**	**CLASS III** **Major Services**
Deductible waived, Paid at 100%	Paid at 80%	Paid at 50%
Cleanings	Anesthesia	Bridges
Exams	Endodontics	Crowns
Fluoride**	Fillings	Dentures
Sealants**	Oral Surgery	Inlays
Space Maintainers**	Periodontics	Onlays
X-Rays	Simple Extractions	TMJ
***Limited to dependents under age 16.*		

INTRODUCTION

Diocese of Yakima, hereinafter referred to as the "Company," as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons," and the eligible dependents of such Participants.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of Covered Dental Expenses. This Plan Document will also serve as the Summary Plan Description.

APPLICABLE LAW

This Dental Plan is established and maintained by a church ("church plan") for the benefit of its Employees and their Dependents. As such, it is exempt from the Employee Retirement Income Security Act of 1974 (ERISA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

This Dental Plan is also an excepted benefit as defined by, and therefore not subject to, the Patient Protection and Affordable Care Act of 2010 (the "Affordable Care Act" or ACA). The Dental Plan provides coverage and benefits in accordance with the requirements of all applicable provisions of the Family and Medical Leave Act of 1993 (FMLA), Title I of the Genetic Nondiscrimination Act of 2008, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Qualified Medical Child Support Orders (QMCSO), and the Uniformed Services and Employment and Reemployment Rights Act of 1994 (USERRA).

EFFECTIVE DATE

The original Effective Date of the Plan is November 1, 2016, and this Plan Document was restated effective November 1, 2018, and has been amended as follows:

Amendment # 1 (effective November 1, 2020).

PLAN SPONSOR

The Plan Sponsor is the Company, whose business address and telephone number is:

Diocese of Yakima

Physical Address:[1]
101 S 12th Avenue
Yakima, WA 98902
Phone: (509) 965-7117

Mailing Address:
PO Box 2189
Yakima, WA 98907

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the Company, whose street address and telephone number is:

Same as above.

CONTRIBUTIONS

Employees may be required to pay a portion of the cost of coverage for themselves and their eligible dependents. The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor to the extent allowed by applicable law.

The amount of contributions to the Plan is to be made on the following basis:

[1] Effective September 1, 2020.

1. The Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Plan Sponsor (if any) and the amount to be contributed (if any) by each Participant. Any amounts paid by the Plan Sponsor shall be paid out of its general assets.

2. Notwithstanding any other provision of the Plan, the Plan Sponsor's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor's obligation with respect to such payments.

3. In the event that the Plan Sponsor terminates the Plan, then as of the Effective Date of termination, the Plan Sponsor and Participants shall have no further obligation to make additional contributions to the Plan.

PROTECTION AGAINST CREDITORS

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 Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Participant, his spouse, adult child, guardian of a minor child, or other relative of a dependent of such covered Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

ELIGIBILITY

WHO MAY RECEIVE BENEFITS

Benefits are provided to Eligible Employees of the Company and their Eligible Dependents. New Employees (and their Dependents) are eligible to participate in the Plan on the first day of the month following a New Employee's date of hire.

EMPLOYEES

"Employee" means an individual classified by the Employer as a common law employee of the Employer, determined in accordance with rules and regulations issued by the Internal Revenue Service. Such term shall not include individuals classified by an Employer as independent contractors (including any person who later becomes reclassified as an employee by the Internal Revenue Service or a court of competent jurisdiction). Any individual who pays or agrees to pay self-employment tax in lieu of withholding shall be deemed to be an independent contractor.

Eligible Employees include:

Full-time Employees. Regular, full-time employees reasonably expected to work at least 30 hours per week.

Part-time Employees. Part-time employees who are reasonably expected to work less than 30 hours per week, but who work at least 20 hours per week.

Academic Employees. An employee who teaches no less than one-half of a regular, full-time academic employee.

Seminarians.

Clergy. Active incardinated priests of the Diocese of Yakima.

Retired Clergy. Members of the clergy who retire at age 65 or older with at least 25 years of service to the Diocese of Yakima or clergy members whose early retirement is approved by the Bishop.

Ineligible Employees. Part-time Employees who work less than 20 hours per week and temporary Employees are not eligible to participate in the Plan.

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are also excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

DEPENDENTS

An Eligible Employee must be enrolled in the Plan for a Dependent to also be covered. Dependents may enroll only in the same benefits in which the Employee has enrolled. However, a Dependent is not required to enroll in all of the benefits in which the Employee has enrolled.

Eligible Dependents include:

Spouses. Spouse means the lawful spouse of an Employee, unless legally separated or divorced. The Plan Administrator may require documentation establishing a legal marital relationship. Common law marriages are not recognized under this Plan. A Spouse shall be a "dependent" for purposes of this Plan.

Children. Children include any eligible child under age 26, regardless of financial dependency, residency with a parent, marital status, or student status. An eligible Child shall include the following:

1. Natural or legally adopted children (including any child placed in the home during a probationary period prior to the adoption);
2. Step-children;
3. Foster children or any other child for whom the Employee is the court-appointed legal guardian;
4. Eligible children for whom the Employee is required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN); *see* the section titled **FEDERAL LAWS AND REGULATIONS**, subsection QUALIFIED MEDICAL CHILD SUPPORT ORDER for additional information;

5. Continued eligibility for children with a physical or mental impairment—Coverage may continue beyond the limiting age for children described above who are unable to support themselves because of a developmental or physical disability with no age limitation if the following has been met:

   a. The child became disabled before reaching the limiting age; and

   b. The child is incapable of self-sustaining employment by reason of a developmental or physical impairment and is chiefly dependent upon the subscriber for support and maintenance; and

   c. The Employee is covered under this plan; and

   d. The child's required contribution for coverage, if any, continues to be paid; and

   e. Within 31 days of the child reaching the limiting age or the child's original effective date under this Plan, whichever is later, the Employee furnishes the Claims Administrator documentation of the disability form the child's primary medical Physician. The Claims Administrator must approve the request for certification for coverage to continue; and

   f. The Employee provides the Claims Administrator with proof of the child's disability and dependent status within 90 days of when we request it. Proof will not be required more often than once a year following the child's attainment of the limiting age; and

   g. The child is the Employee's tax dependent as defined by the IRS.

NOTE:

- ✓ If both Spouses are Employees, each Spouse may be covered only as an Employee and not as a Dependent (Spouse) of the other.
- ✓ If both parents of a Dependent Child(ren) are Employees, the Child(ren) may be covered as a Dependent of either parent, but not both.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

Within 31 days of Eligibility, an Employee must properly complete plan enrollment forms to be covered by this Plan. Enrollment forms may be obtained at the Human Resources Office.

New dependents of Employees must be enrolled in this Plan within 31 days of the date of marriage or the date upon which the Employee becomes Eligible to participate in the Plan. Newborns, newly-Adopted or Foster Children must be enrolled within 60 days from date of birth or permanent placement within the home.

If an Employee declines coverage by signing a "Waiver of Coverage" form, he and his Dependents may only enroll at the next Open Enrollment. If an Employee declines enrollment for himself or his dependents (including a spouse) because of other health insurance or group health plan coverage, however, the Employee may be able to enroll himself or his dependents in this plan if any of them lose eligibility for that other coverage as described below in SPECIAL ENROLLMENT.

CHANGES IN ENROLLMENT

The Human Resources Office must be notified immediately if any change occurs that may affect eligibility to participate in this Plan.

WHEN COVERAGE BEGINS

Provided that written application for health care coverage is completed as required above, coverage is effective for new Employees and their eligible Dependents on the first day of the month coinciding with or following the date of hire.

New Dependents may not be enrolled or covered before the Employee becomes Eligible to participate in the Plan. If the Employee is already Eligible, new Spouses and Step-Children, if any, will be covered as of the date of marriage. Newborns will be covered from the date of birth, and newly-Adopted or Foster Children will be covered on the date of permanent placement in the home whether by legal agreement or court order on custody.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

OPEN ENROLLMENT

You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the month of October for coverage to be effective November 1st.

REINSTATEMENT OF COVERAGE

Employees rehired after termination from employment or returning after an approved leave of absence within six (6) months will be reinstated on the first day of the month coinciding with or following the Employee's return to work. Dependents covered on the Employee's date of separation or leave from employment, and any new dependents acquired during the absence, are included in this provision.

If an Employee was eligible to participate in the Plan prior to the date of separation, but had not enrolled, the Employer must offer coverage to the Employee on the start date of his return to work. If the Employee elects to enroll upon his return, he may also enroll any eligible Dependents he has on that date. Coverage is effective on the first day of the month coinciding with, or following, the Employee's return to work.

If previously covered under the Plan, an Employee returning to work within six (6) months of absence will be credited with all prior payments made in satisfaction of Deductibles or Out-of-Pocket Maximums upon reinstatement. However, if an Employee returns to work in the following Plan Year, new Deductibles and Out-of-Pocket Maximums may apply.

Employees rehired or returning from an approved leave of absence after six (6) months from the date of separation will be required to re-qualify as a new Employee. New Deductibles, Out-of-Pocket Maximums, Plan Limitations and Waiting Periods will apply.

SPECIAL ENROLLMENT

HIPAA requires a group health plan to offer a Special Enrollment period (regardless of any Open Enrollment period) to Employees and their Dependents who have previously declined coverage under the Plan. To qualify for a Special Enrollment, the Employee and Dependent must be currently eligible for coverage under the terms of this Plan and have had coverage under another group health plan or health insurance when coverage was previously declined.

A Special Enrollment opportunity is triggered if any of the following conditions occur:

1. **Loss of Eligibility for Coverage under a Group Health Plan or Other Health Insurance Coverage.** Loss of Eligibility includes, but is not limited to:

   a. Divorce or legal separation;

   b. A dependent is no longer considered a dependent under the Plan;

   c. Death of the employee covered by the Plan;

   d. Termination of employment;

   e. Reduction in the number of hours of employment;

   f. The Plan decided to no longer offer any benefits to a class of similarly situated individuals; or

   g. An individual in an HMO or other arrangement no longer resides, lives or works in the service area.

   Loss of eligibility ***does not*** include (a) a loss resulting from the failure of the individual to pay premiums on a timely basis; or (b) a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Plan).

2. **Termination of Employer's Contributions.** An Employer's contributions to the Plan are terminated, even if the Employee could continue coverage at the higher cost. This condition also applies if an Employer offers more than one plan option and chooses to terminate the option in which the Employee is enrolled.

3. **Exhaustion of COBRA Coverage.** The Employee or dependent has exhausted his group health plan or health insurance coverage extended under COBRA. Exhaustion includes the following:

   a. Completion of the entire 18- or 36-month COBRA period;

   b. The former Employer failed to remit premiums on a timely basis as previously agreed;

   c. A period of Employer-paid COBRA coverage ended; or

   d. An individual no longer resides, lives or works in the service are in an HMO or other arrangement extended by COBRA.

Conditions 1, 2 and 3 above trigger a Special Enrollment period if the Employee or dependent are currently eligible for coverage under the Plan. The employee or the Dependent must request coverage within 30 days following the occurrence of one of these events. Coverage will be effective on the first day following the loss of other coverage so that there is no lapse in coverage.

4. **Acquisition of a New Dependent.** The Employee has acquired a new Dependent through marriage, birth, adoption, or placement for adoptions. This provision includes the addition of a dependent over the age of 18 who previously lost coverage due to loss of his dependent status, but now again qualifies as a Dependent.

   Enrollment due to marriage (including step-children) must occur within 31 days after the date of marriage. Coverage will be retroactively effective to the date of marriage. New dependents acquired due to birth, placement for adoption, or adoption must be enrolled within 60 days of this event. Coverage will be retroactively effective on the date of birth, adoption, or placement for adoption.

   Enrollment due to regaining dependent status must also occur within 30 days after the date the event occurred. Coverage will be effective on the first day of the month following the change in the dependent's status.

5. **Medicaid or CHIP Eligibility.** A Special Enrollment opportunity is triggered if either a) the Employee or Dependent loses eligibility for state Medicaid or Child Health Insurance Plan (CHIP program); or b) the Employee or Dependent becomes eligible for a premium assistance subsidy under state Medicaid or CHIP. The Employee must request coverage under the Plan within 60 days after either determination of eligibility.

TERMINATION OF COVERAGE

Coverage under this Plan may be extended if: a) the Employee is temporarily absent from work due to Illness or Injury, but only for the duration of unused sick leave and unused vacation time; or b) the Employee's absence is due to a Special Unpaid Leave of Absence.[2] All required contributions to the Plan must be made during such extension.

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate upon the earliest of the following dates:

1. On the last day of the month immediately following the date of termination of the Participant's employment or layoff;
2. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
3. On the date the Participant fails to make any required contribution for coverage;
4. On the date the Plan is terminated;
5. On the date of the Participant's death;
6. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed 30 days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If employment is obtained by misrepresentation or fraud (including misrepresentation of immigration status in obtaining or maintaining employment), coverage is immediately lost under the Plan. Any such loss of coverage because of false representations in obtaining employment would be retroactive to the Employee's original Effective Date.

DEPENDENT TERMINATION

The Dependent Coverage of a Participant shall automatically terminate upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month immediately following the date the dependent ceases to be an eligible dependent under the Plan;
2. On the last day of the month immediately following the date of termination of the Participant's coverage under the Plan;
3. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
4. On the date the Participant fails to make any required contributions for Dependent Coverage;
5. On the date the Plan is terminated;
6. On the last day of the of the month in which the Plan Sponsor terminates the dependent's coverage;
7. On the last day of the month in which the Participant dies; or
8. On the date the dependent enters the armed forces of any country as a full-time member if active duty is to exceed 30 days.

RESCISSION OF COVERAGE

A "rescission" is defined as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage under the Plan is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Two examples involving nonpayment of premiums where coverage may be canceled retroactively:

[2] A "Special Unpaid Leave of Absence" means any of the following legally-mandated unpaid leaves of absence that do not constitute termination of or layoff from employment: (1) leave protected by the Family and Medical Leave Act; (2) leave protected by the Uniformed Services Employment and Reemployment Rights Act; or (3) Jury Duty (as reasonably defined by the Employer).

1. Retroactive terminations in the “normal course of business” are permissible.
2. Retroactive terminations for failure to notify the Plan when dependents covered by the Plan became ineligible.

The Plan is prohibited from rescinding coverage for individuals who are covered under the Plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice.

The Plan is required to provide at least 30 days advance written notice to each individual who would be affected before coverage may be rescinded. This thirty (30)-day period will provide individuals with an opportunity to explore their rights to contest the rescission or look for alternative coverage, as appropriate.

Coverage will be canceled prospectively to correct errors in coverage, such as mistakenly covering a part-time Employee, but not by retroactively rescinding coverage, unless there was some fraud or intentional misrepresentation by the individual.

The Plan reserves the right to recover from the Employee and his covered dependents any benefits paid as a result of the wrongful activity that is in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on the part of the Employee, as determined by the Employer, continuation coverage under COBRA may be denied to the Employee and his covered dependents.

CONTINUATION PRIVILEGE

This Plan provides a voluntary option to continue Dental coverage for up to six months following termination. Former Employees and their Dependents are eligible for continued coverage if the loss of coverage is due to termination of employment; leave of absence; loss of employee eligibility; loss of dependent eligibility; death of an Employee; disability; or divorce. Employees must pay the full cost of the continued coverage as determined by the Plan Administrator.

Contact your Employer to confirm eligibility for the Continuation Privilege and to complete the proper enrollment forms.

NOTE: This Plan is exempt from providing COBRA continuation coverage to its Employees at their termination.

Church plans are not required to give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a loss of coverage under an employer's plan.

The CONTINUATION PRIVILEGE, described above, is not COBRA coverage, and provides coverage for a limited period of time following termination.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The Family and Medical Leave Act is a federal law that allows Eligible Employees of a Covered Employer to take either paid or unpaid leave to care for family members. An Eligible Employee is entitled to continue health care coverage under this Plan during a period of employer-approved, FMLA leave at the same cost as if the FMLA leave had not been taken.

If provisions under the Plan change while you are on FMLA leave, the changes will be effective for you on the same date as they would have been had you not taken leave.

Eligible Employee. An Employee is eligible for FMLA leave, if the Employee:

1. Has been employed by the Employer for at least 12 months on the date which any FMLA leave is to commence; and
2. Has been employed for at least 1,250 hours of service during the 12-month period immediately preceding the commencement of the leave; and
3. Is employed at a work-site with 50 or more Employees within a 75-mile radius of other work-sites of the Employer.

Circumstances Qualifying for FMLA Leave. Covered Employers are required to grant leave to Eligible Employees for the following circumstances:

1. Birth of a son or daughter and to care for the newborn child;
2. Placement of a child with the Employee for adoption or foster care;
3. To care for the Employee's spouse, son or daughter, or parent with a serious health condition; or
4. Because of a serious health condition that makes the Employee unable to perform the Employee's job functions; or
5. Because of a qualifying exigency arising out of the fact that the Employee's Spouse, Son, Daughter, or Parent, is a military member on covered active duty or has been notified of an impending call or order to covered active duty status in the Armed Forces in support of a contingency operation (i.e. a war or similar combat operation).
6. To care for a covered service member with a serious injury or illness if the employee is the spouse, son, daughter, parent or next of kin of the covered service member.

Coverage under FMLA leave is limited to a total of 26 workweeks during any 12-month period that follows a Serious Illness or Injury of a service member when the Employee is that service member's Spouse, Son or Daughter, Parent, or Next of Kin.

FMLA leave may be paid or unpaid, but runs concurrently with any other similar type of leave available. Federal FMLA allows an Employer to require an employee to use all paid leave (such as, accrued vacation leave, personal leave, medical or sick leave, or family leave) before using unpaid leave.[3] Consult with your HR Department or your Employee Handbook to confirm your Employer's policy for using paid and unpaid leave while on FMLA.

[3] Many states provide other forms of protected family and medical leave. Effective January 1, 2020, Washington state is implementing a new Paid Family and Medical Leave (PFML) that prohibits employers from *requiring* an employee to take other forms of paid time off in lieu of or concurrently with PFML.

You must continue to pay your portion of the Plan contribution, if any, during the FMLA leave. Payment must be made within 30 days of the due date established by the Plan Administrator. If payment is not received, coverage will terminate on the last date for which the contribution was received in a timely manner.

GENETIC INFORMATION NONDISCRIMINATION ACT

Under the Genetic Information Nondiscrimination Act of 2008 ("GINA"), an employer may not discriminate, harass, or retaliate against an employee in any aspect of employment because of Genetic Information. Genetic Information includes an individual's genetic tests; genetic tests of that individual's family members; manifestation of a genetic disease or disorder in the individual's family medical history; an individual's request for, or receipt of, genetic services or participation in clinical research; or genetic information of a fetus carried by an individual or by a pregnant woman who is a family member of the individual. *See* 29 CFR 1635.3.

GINA prohibits an employer from using an individual's Genetic Information in hiring, discharge, compensations, terms, conditions, or privileges of employment. An employer may not request, require, or purchase genetic information about an individual. Any genetic information voluntarily provided by an individual must be maintained as a confidential medical record and strictly limits the disclosure of genetic information about an employee.

HIPAA PRIVACY[4]

Diocese of Yakima (the "Plan Sponsor") sponsors the Diocese of Yakima Dental Care Benefits Plan (the "Plan"). Members of the Company's workforce have access to the individually identifiable health information of Plan Participants for the administrative functions of the Plan. When this health information is provided by the Plan to the Plan Sponsor, it is Protected Health Information.

Commitment to Protecting Health Information. The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take Reasonable steps to ensure the privacy of the Plan Participant's PHI and inform him about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed. In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes. In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

[4] This section does not constitute the triennial HIPAA Privacy Notice. Contact your Plan Sponsor for a copy.

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

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for Payment or Plan Health Care Operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

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

8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

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

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following Employees, classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: the Privacy Officer, Controller, Office Manager, HR Specialist, and President. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan.

    b. In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose Reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor. Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage. The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss

carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Primary Uses and Disclosures of PHI.

1. *Treatment, Payment and Health Care Operations*. The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

2. *Business Associates*. The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

3. *Other Covered Entities*. The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI.

1. *Required by Law*. The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. *Public Health and Safety*. The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
   a. A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
   b. Report reactions to medications or problems with products or devices regulated by the federal food and drug administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
   c. Locate and notify persons of recalls of products they may be using; and
   d. A person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. *Abuse or Neglect*. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by 2(a) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. *Health Oversight Activities*. The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.

5. *Lawsuits and Disputes*. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. *Law Enforcement*. The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are

suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. *Decedents*. The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. *Research*. The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. *To Avert a Serious Threat to Health or Safety*. The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. *Workers' Compensation*. The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. *Military and National Security*. The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI.

1. *Disclosures to Plan Participants*. The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a Reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. *Disclosures to the Secretary of the U.S. Dept. of Health and Human Services*. The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Individual's Rights. The Plan Participant has the following rights regarding PHI about him/her:

1. **Request Restrictions.** The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to Family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. **Right to Receive Confidential Communication.** The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all Reasonable requests.

3. **Copy of This Notice.** The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Officer.

4. **Accounting of Disclosures.** The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Officer.

5. **Access.** The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she

may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Officer. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. **Amendment.** The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints. If you want more information about the Plan's Privacy practices, have questions or concerns, or believe that the Plan has violated your Privacy Rights, contact the Plan Administrator using the contact information below:

Diocese of Yakima

Physical Address:	*Mailing Address*:
101 S 12th Avenue	PO Box 2189
Yakima, WA 98902	Yakima, WA 98907
Phone: (509) 965-7117	

You may also file a complaint with the U.S. Department of Health and Human Services for Civil Rights by: 1) sending a letter to 200 Independence Avenue SW, Washington DC 20201; 2) calling (877) 696-6775; or 3) visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

HIPAA SECURITY STANDARDS

The Plan Sponsor shall have access to Electronic Protected Health Information (Electronic PHI) from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Electronic PHI in a manner inconsistent with 45 CFR 164.504(f).

The Diocese of Yakima Dental Care Benefits Plan (hereinafter the "Plan") intends for this section to comply with the requirements of 45 CFR 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 CFR Parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor obligations with respect to the security of Electronic Protected Health Information.

Definitions.

"Electronic Protected Health Information" (ePHI) is defined in Section 160.103 of the Security Standards (45 CFR 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

"Health Breach Notification Rule" is defined in 16 CFR Part 318, as amended from time to time, and generally means as the acquisition of unsecured PHR identifiable health information of an individual in a personal health record without the authorization of the individual.

"Protected health information" means individually identifiable health information that is transmitted by electronic media; maintained in electronic media; or transmitted or maintained in any other form or medium.

"Security Incidents" is defined within Section 164.304 of the Security Standards (45 CFR 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions: Standards for Security of Individually Identifiable Health Information ("Security Rule"). The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Plan Sponsor Obligations. To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures and to report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI. In accordance with the Health Breach Notification Rule (16 CFR Part 318), the required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual who's PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

NONDISCRIMINATION

The Diocese of Yakima Dental Care Benefits Plan does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan also does not apply any health factors[5] when determining a participant's eligibility to enroll in the Plan or a participant's benefit coverage, as required by HIPAA.

As required by Internal Revenue Code Section 105(h)(2), the Plan does not discriminate in eligibility to participate or benefits provided in favor of highly compensated individuals. All rules, procedures, and decisions of the Plan Administrator shall be made, adopted, and applied in such fashion as to not discriminate in favor of Highly Compensated or Key Employees. The Plan Administrator shall take such actions necessary to ensure that the Plan does not reduce or adjust contributions and/or benefits in a discriminatory manner.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a medical child support order that creates or recognizes the right of a Participant's eligible Dependent to receive benefits under the Plan. A National Medical Support Notice (NMSN) is treated as a QMCSO if properly executed. Either a court or administrative agency with the authority to enter a child support order may issue a QMCSO or NMSV.

The Claims Administrator is responsible for processing a QMCSO or NMSV. Upon receipt of either, the Claims Administrator must notify the Participant and the "Alternate Recipient" (or Dependent child) that it has received such an order. Then the

[5] "Health factors" include health status, medical conditions, including physical and mental illnesses; claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Claims Administrator must determine whether the order is "qualified" as defined below. When the Claims Administrator had made its decision, it must provide notice of its determination to the Participant, the Dependent child, and the issuing agency.

A "qualified" order designates the type of coverage (e.g. medical, dental, or all coverage available) in which the Dependent child must be enrolled. If the Plan has more than one coverage option, the Claims Administrator must notify the issuing agency of the available options. If the issuing agency does not respond within 20 days of notice, the Claims Administrator may enroll the Participant and/or the Dependent child under "default" options.

An order that requires coverage that is not available under the Plan is not a qualified order (e.g. vision coverage, but the Plan offers medical and dental only). The Claims Administrator is not required to take any additional action other than to notify the Participant, the Dependent child, and the issuing agency of its determination.

If the Claims Administrator determines that the order is qualified, it may enroll the child in the Plan. If the Participant must be enrolled for the Dependent(s) to be eligible, the Claims Administrator may also enroll the Participant in the Plan. A Participant may not terminate coverage unless allowed to do so under the terms of the Plan or the order.

For more information about QMCSO or NMSN Orders, please contact your Employer or Human Resources Department.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Under USERRA, Employers must reemploy returning servicemembers (former Employees) in the same or comparable job as if there had been no military absence.

In addition, an Employee going into military service may elect to continue Plan coverage. Rights to continue coverage apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Coverage may be continued as follows:

1. **Active Duty for 30 Days or Less.** Coverage may continue as if the servicemember had remained employed;
2. **Active Duty for Less than 24 Months.** Coverage may continue for the period beginning on the date that military leave commenced and ends on the day after the date upon which the person was required to apply for, or return to, employment, but fails to do so; or
3. **Active Duty for 24 Months.** Coverage may continue for a 24-month period beginning on the date that Uniformed Service leave commences.

If coverage is continued for 31 days or more, the Plan may require an Employee to pay up to 102% of the full contribution under the Plan.

Regardless of whether an Employee elects to continue coverage during military service, the Employee has the right to be reinstated in the health plan when reemployed. Generally, no waiting periods or exclusions may be applied, except for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

For more information about any of these mandatory federal rights, please contact the Plan Administrator, your Human Resources Department, or TPSC Member Services at (800) 426-9786.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate any applicable Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

ALTERNATE TREATMENT

If an Alternate Treatment is being considered for a current oral condition instead of a service or supply that is customarily used in your geographic area for treatment of that condition, it must meet broadly accepted standards of dental practice. If the Alternate Treatment is more expensive, the Plan's coverage is limited to the Usual & Customary and/or Reasonable (UCR) charges for the more common treatment.

ANNUAL MAXIMUM BENEFIT

Dental benefits are payable at the applicable coinsurance up to the Annual Maximum Benefit, as shown in the **DENTAL SUMMARY OF BENEFITS**.

BENEFIT LIMITATIONS

All services and supplies are limited to a Usual & Customary and/or Reasonable (UCR) Allowance as determined by the Plan Administrator.

COINSURANCE

Coinsurance is the percentage share payable by the Covered Person on claims for which the Plan provides benefits at less than 100% of the allowed amount.

DEDUCTIBLE

The Deductible is the dollar amount of Covered Dental Expenses that must be Incurred during the year before the Plan pays for any other Covered Expenses (as shown in the **DENTAL SUMMARY OF BENEFITS**).

DENTAL PLAN EXPENSES INCURRED

Dental Expenses are covered only if Incurred and completed while a Covered Person is covered under this Plan. Expenses are deemed to be Incurred as follows:

1. For root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex;
2. For fixed Bridgework, Crowns, Inlays or Onlays, on the date the tooth or teeth are fully prepared;
3. For full or partial dentures, on the date on which the final impression is made; or
4. For all other expenses, on the date the service is performed or a supply is furnished.

INTEGRAL DENTAL PROCEDURES

Some dental services are considered an integral part of the entire dental procedure rather than a separate service, including, but not limited to, local anesthesia, bases, pulp caps, temporary dental services, diagnostics casts or study models, treatment plans, and occlusal adjustments.

EXTENSION OF DENTAL BENEFITS AFTER TERMINATION

Benefits will be extended after termination of coverage if the following expenses were Incurred prior to termination:

1. For root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex;
2. For fixed Bridgework, Crowns, Inlays or Onlays, but only if the tooth or teeth was fully prepared; or
3. For full or partial dentures, but only if the final impression was made.

Treatment must be completed within 60 days after coverage is terminated. Extended benefits will not be paid on or after the date a Covered Person becomes eligible for other group dental coverage.

BENEFITS PROVIDED BY YOUR DENTAL PROGRAM

The following are Class I, Class II, and Class III covered dental benefits. There is no dental provider network. Services may be received from the Covered Person's dental provider of choice. All dental benefits are subject to the Dental Limitations and Exclusions below.

CLASS I PREVENTIVE & DIAGNOSTIC BENEFITS

Covered Diagnostic Services.

1. **Exams.** Routine examinations.
2. **Emergency Examination.**
3. **X-rays/Panorex.** Bitewings; Panorex complete mouth x-rays; vertical bitewing; occlusal, periapical, or extraoral x-rays.
4. **Palliative Treatment.**

Covered Preventive Services.

1. **Cleanings.** Prophylaxis.
2. **Fluoride.** Topical application of Fluoride.
3. **Sealants.** Pit and fissure sealants.
4. **Space Maintainers.** Used to maintain space for eruption of permanent teeth.

Class I Limitations.

1. **Cleanings.** Prophylaxis is covered two (2) times per Calendar Year.
2. **Emergency Exams.** Emergency exams are covered if no other service is provided except for X-rays.
3. **Exams.** Routine examination is covered two (2) times per Calendar Year.
4. **Fluoride.** Topical application of Fluoride is covered two (2) times per Calendar Year when performed in conjunction with a Prophylaxis, up to age sixteen (16).
5. **Sealants.** Pit and fissure sealants are limited to first and second permanent molars and to one (1) treatment per two (2) Calendar Years for Dependent Children up to age sixteen (16).
6. **Space Maintainers.** Includes fixed or removable, unilateral or bilateral space maintainers when needed to preserve space resulting from premature loss of primary teeth and all adjustments within six (6) months after installation. Limited to Dependent Children up to age sixteen (16).
7. **X-Rays/Panorex.** Adult bitewings are covered once per Calendar Year. For children under age 18, bitewings are limited to two (2) times per Calendar Year. Complete mouth or Panorex X-rays and vertical bitewings are covered once per three (3) Calendar Years. Extraoral X-Rays (such as Sialography, TMJ, Cephalometric film, posterior-anterior or lateral skull, or facial bone surveys) are limited to two (2) x-rays per Calendar Year.

Class I Exclusions.

1. **Caries Susceptibility Tests.**
2. **Plaque Control Program.** Oral hygiene instruction, dietary instruction, and home Fluoride kits.
3. **Root Canal.** Diagnostic x-rays performed in conjunction with a root canal are not covered under Class I benefits.
4. **Replacement.** Charges for replacement of a Space Maintainer previously covered under this Plan.
5. **Study Models.**

CLASS II BASIC SERVICES

Covered Basic Services.

1. **Antibiotic Drug Injection.**
2. **Adjustments to Prosthetic Appliances.**
3. **Dental Consultation.** Consultation with a specialist in an American Dental Association recognized specialty, including, but not limited to: (a) restorative/prosthodontic services; (b) endodontic services; (c) periodontic services; (d) oral surgery; or (e) pedodontics.
4. **Nightguard/Occlusal Guard.** Nightguards or Occlusal Guards are removable devices that fit over the teeth and are used to help prevent the wearing down of teeth during sleep due to night time grinding and clenching (bruxism).
5. **Pontics.** Addition of tooth to Partial Denture.
6. **Recementing.** Recementing of Inlay, Onlay, Crown, or Bridge.
7. **Relining or Rebasing.** Complete or partial denture (upper or lower) if more than one year after initial placement.
8. **Tissue Conditioning.** Tissue conditioning after insertion of a complete or partial denture.

Covered Endodontic Services.

1. **Endodontic Services.** Covered services include apexification, apiocoectomy, root resection, retrograde filing, and hemisection.
2. **Pulp Vitality Test.**
3. **Pulpal Therapy.** Services covered include pulp capping and pulpal debridement.
4. **Pulpotomy.** Deciduous teeth only.
5. **Root Canal Therapy.** Root canal therapy including retreatment, treatment of root canal obstruction, inoperable or fractured tooth, or internal root repair of perforation defects. Includes diagnostic x-rays, clinical procedures and follow-up care.

Covered Oral Surgery Services.

1. **Extractions.** Removal of teeth and surgical extractions, preparation of the Alveolar ridge and soft tissue of the mouth for insertion of dentures.
2. **General Anesthesia and I.V. Sedation.**
3. **Other Services.** Treatment of pathological conditions and traumatic facial Injuries.

Covered Periodontic Services.

1. **Full Mouth Debridement.** Gross removal of plaque and calculus so that a comprehensive oral examination and diagnosis may be completed.
2. **Periodontal Evaluation.**
3. **Periodontal Maintenance (Prophylaxis).** Specialized cleaning (prophylaxsis) following periodontal scaling and root planing to maintain health of tooth roots, gums, and bone affected by periodontal disease.
4. **Periodontal Surgery.** Includes gingival flap procedures; gingivectomy; gingival curettage; osseous surgery; pedicle soft tissue graft; free soft tissue graft; or osseous graft.
5. **Scaling and Root Planing.** Deep cleaning of tooth roots, gums and bones to interrupt progression of periodontal disease. Includes localized delivery of antimicrobial agents.

Covered Restorative Services.

1. **Fillings.** Amalgam, silicate, plastic or composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure.
2. **Pins/Pin Retention.** Covered per tooth in addition to amalgam or resin restorations.

3. **Stainless Steel Crowns.** Stainless steel crowns for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).

Class II Limitations.

1. **Adjustments.** Adjustments to prosthetic appliances are limited to one adjustment per Calendar Year and only if it has been at least one year since installation.
2. **Amalgam Allowance.** If a Composite or plastic restoration is placed on a Posterior Tooth, an Amalgam allowance will be made for such procedure.
3. **Full Mouth Debridement.** Limited to once per two (2) Calendar Years.
4. **General Anesthesia and I.V. Sedation.** Limited to complex oral surgical procedures otherwise covered by this Plan. Nitrous oxide is not covered.
5. **Nightguard or Occlusal Guard.** Limited to one appliance per 3 years.
6. **Periodontal Maintenance (Prophylaxis).** Periodontal Maintenance (Prophylaxis) is covered four (4) times per Calendar Year following active periodontal treatment.
7. **Periodontal Surgery.** Limited to one (1) surgical procedure per quadrant per 2 years.
8. **Pulpotomy.** Pulpotomy or Partial Pulpotomy are limited to deciduous teeth only.
9. **Restorations.** Restorations on the same surface(s) of the same tooth are covered as a single filling. Replacement fillings are covered once per two (2)-year period unless required by new decay in an additional tooth surface.
10. **Root Canal.** Root canal treatment on the same tooth is covered only one (1) time per two (2) Calendar Years.
11. **Scaling and Root Planing.** Scaling and root planing are covered once per quadrant per two (2) Calendar Years (i.e., all four (4) quadrants may be treated within two (2) Calendar Years).
12. **Stainless Steel Crowns.** Stainless steel crowns are covered once per two (2) year period.

Class II Exclusions.

1. **Cosmetic Procedures.** Services or supplies primarily cosmetic in nature, including teeth bleaching.
2. **Extraoral Grafts.** Grafts of tissues from outside the mouth or use of artificial materials.
3. **Limited or Major Occlusal Adjustment.**
4. **Harmful Habit Appliances.**
5. **Overhang.** Overhang removal, re-contouring, or polishing of restoration.
6. **Periodontal Splinting.** Includes Crown and/or bridgework in conjunction with periodontal splinting.
7. **Restorations.** Restorations necessary to correct vertical dimension or to restore the occlusion.
8. **Tooth Transplants.**
9. **Vestibuloplasty.** Ridge extension for insertion of dentures.

CLASS III MAJOR BENEFITS

Covered Prosthodontic Services.

1. **Fixed Bridges.** Installation and repair of one or more artificial teeth attached by Crowns to adjacent teeth. Used to maintain space and function for missing teeth.
2. **Dentures.** Removable partial or complete dentures.
3. **Implants.** Prosthetic appliances placed into or on bone of the maxilla or mandible (upper or lower jaw) to retain or support a dental prosthesis.
4. **Repairs.** Repairs to prosthetic appliances, such as bridges and complete or partial dentures.

Covered Restorative Services.

1. **Core Build-Up.** Placement of material (core) that will serve as the foundation of a crown when large portions of the tooth are missing due to decay, fracture, loss of a filling, or an access cavity (root canal).
2. **Crowns, Inlays, Onlays and Labial Veneers.** Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of tooth decay) or fracture resulting in significant loss of tooth structure (missing cusp), and the tooth cannot be restored with a filling. Materials for the restoration include gold, porcelain, plastic, stainless steel, gold-substitute castings or combinations thereof.
3. **Post and Core.** Covered only for teeth following root canal therapy.
4. **Steel Post and Composite or Amalgam.** Covered only for teeth following root canal therapy.

Covered Temporomandibular Joint Disorder (TMJ) Services.

1. **Oral Appliances.** Covers oral appliances used to specifically treat TMJ.

Class III Limitations.

1. **Amalgam Allowance.** If a tooth can be restored with a filling material such as Amalgam, silicate or plastic, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. Verification that teeth cannot be restored with filling materials such as Amalgam, silicate or plastic must be provided before use of other materials.
2. **Crowns, Inlays, Onlays and Labial Veneers.** Crowns, Inlays, Onlays or Labial Veneers on the same tooth are limited to once per five (5) year period.
3. **Full or Partial Dentures.** If a more elaborate or precision device is used to restore the case, this Plan will allow the cost of a cast chrome and acrylic full or partial denture toward the cost of any other procedure that may be provided.
6. **Temporomandibular Joint Disorder (TMJ).** Treatment for TMJ requires pre-authorization from the Plan Administrator.
7. **Replacement.** Replacement of a prosthetic device will apply only if:
    a. The existing prosthetic device was installed at least five (5) years prior to its replacement, and
    b. It is unserviceable and cannot be made serviceable.

Class III Exclusions.

1. **Abutment.** A Crown used as an abutment to a partial denture is not covered unless the tooth is decayed to the extent that a Crown would be required to restore the tooth whether or not a partial denture is required.
2. **Cleaning of Prosthetic Appliances.**
3. **Crowns and Copings.** Crowns and copings in conjunction with Overdentures.
4. **Dentures.** Duplicate and temporary dentures.

DENTAL PLAN LIMITATIONS AND EXCLUSIONS

1. **Congenital Malformation.** Charges for services or supplies used to correct a congenital malformation, except as provided for Medically Necessary Orthodontia above;

2. **Coordination of Benefits.** Charges that are payable in whole or part of any Covered Expense that is payable under the Employer's Health Care Benefits Plan, unless:

   a. Benefits are payable under both the Dental and Medical Plans; and

   b. It is to the Covered Person's advantage to have benefits paid under Dental benefits rather than under Medical benefits;

3. **Cosmetic Procedures.** Charges for services for procedures primarily Cosmetic in nature including, but not limited to, laminates or bleaching of teeth; facings or veneers; or other customized dental procedures; precision or other elaborate attachments for any appliance;

4. **Dentist Supervision.** Charges by any person other than a Licensed Health Care Provider and whose services are included in that Dentist's charge;

5. **Duplicate Charges.** Charges resulting from changing from one Licensed Health Care Provider to another while receiving treatment, or from receiving care from more than one Licensed Health Care Provider for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one Licensed Health Care Provider had performed all the required dental services;

6. **Error.** Any charge for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

7. **Excluded Drugs.** Charges for analgesics (such as nitrous oxide) or any other euphoric drugs; prescription drugs; or application of desensitizing medicaments;

8. **Experimental and/or Investigational Services.** Charges for Experimental and/or Investigational procedures or services whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are Experimental and/or Investigational, this Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community where the services were provided; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to the Experimental and/or Investigational Exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request;

9. **Foreign Dental Services.** Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining dental services, drugs, or supplies;

10. **Hospitalization for Dental Care.** Charges for Hospitalization or outpatient surgical center charges and any additional fees charged by the Dentist for Hospital treatment, except as needed for disabled dependents, or if such hospitalization or outpatient surgical center treatment is deemed Medically Necessary by the attending Physician and/or Licensed Health Care Provider based on the individual needs or circumstances of the patient;

11. **Illegal Activities.** Any charge for care, supplies, treatment, and/or services for dental Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. 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 medical condition (including both physical and mental health conditions);

12. **Legal Obligation.** Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;

13. **Motor Vehicle Accident.** Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage;

14. **Necessity.** Services and supplies that are not Necessary for treatment of a dental Injury or disease or that are not recommended and approved by the Licensed Health Care Provider attending the patient;

15. **Negligence.** Any charge for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Dentist or Dental practitioner;

16. **Non-Covered Services or Supplies.** Any other services or supplies that are not specifically listed as a benefit of this Plan.

17. **Non-Dental Charges.** Charges for missed or cancelled appointments; and for telephone or electronic consultations; mailing and/or shipping and handling expenses; or expenses for preparing reports, itemized bills or claim forms. This Exclusion does not apply to expenses incurred by the Plan for utilization review, audits or investigation of a claim for benefits if approved by the Claims Administrator;

18. **Orthognathic Surgery.** Charges for augmentation or reduction of the upper or lower jaw;

19. **Professional Athletics.** Charges for Injuries related to participation in professional or semi-professional athletics, including practice, except as covered as a Dental Injury in the Medical Plan;

20. **Relatives or Household Members.** Charges for services rendered by any provider that is a Close Relative of the Covered Person, or that resides in the same household of the Covered Person;

21. **Replacement.** Charges for replacement of dental appliances or prosthetic devices that have been lost, broken, or stolen;

22. **Subrogation, Reimbursement, and/or Third Party Responsibility.** Any charge for care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's Third Party Recovery, Subrogation and Reimbursement provisions, which appear elsewhere in this Plan Document;

23. **Usual & Customary and/or Reasonable (UCR) Charges.** Charges in excess of the Usual & Customary and/or Reasonable (UCR) charge for the services or supplies provided, or which exceed the UCR charges for the least costly plan of treatment when there is more than one accepted method of treatment for the dental condition;

24. **War or Terrorist Act.** Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared; and

25. **Worker's Compensation.** Services for Injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, or arising out of, or in the course of, any work for wage or profit; or services which are provided to the eligible person by any federal, state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("Claimants") to obtain payment of dental benefits under this Plan.

CLAIMS DEFINITIONS

"*Assignment of benefits*" means an arrangement whereby the Claimant assigns their right to seek and receive payment of benefits provided under this Plan to a Dentist or Licensed Health Care Provider. If a provider accepts an "Assignment of Benefits" for services, supplies, and/or treatment rendered, the provider's rights are the same as those of the Plan Participant.

"Claim for benefits" means any request for a plan benefit or benefits made by a Claimant in accordance with a plan's reasonable procedures for filing benefit claims.

"Claimant" means an individual who makes a claim for payment or reimbursement of costs as a benefit under this Plan. The term Claimant may also include an *"authorized representative."*

"Clean Claim" means a claim for benefits that may 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 that has no defect or impropriety. A defect or impropriety includes a lack of required supporting 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 to establish Usual & Customary, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

DENTAL CLAIMS

The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them.

The Plan Administrator may delegate the responsibility to process claims in accordance with the Plan Document [and Summary Plan Description] to a Claims Administrator; provided, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

The Plan Administrator in its sole discretion may require written proof that the expenses were Incurred or that the Plan in fact covers the claimed benefit. Each Claimant is responsible for supplying, written proof that the expenses were Incurred or that the Plan in fact covers the benefit. If the Claimant fails to furnish such proof as requested, the Plan will pay no benefits to the Claimant.

If a Claimant has any questions regarding eligibility, benefits or filing claims, contact the TPSC Claims Administrator at (800) 426-9786.

WHEN DENTAL CLAIMS MUST BE FILED

Dental claims must be filed with the Claims Administrator within twelve (12) months from the date charges for the service were Incurred.[6] Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.**

HOW TO FILE A CLAIM

Most Dental Care Providers will file claims on the Claimant's behalf. Electronically submitted claims are processed most efficiently. If unable to file electronically, the Covered Person, his Dentist and/or Licensed Health Care Provider, or an authorized representative must file a "paper" claim as described below.

[6] If the Plan is terminated for any reason, final claims must be received within ninety (90) days of termination.

Required Claim Information. The following information is required in order to qualify a request for benefits as a Clean Claim (as defined above):

1. The Company/Employer name;
2. The Plan Participant's name, ID number and current address;
3. The patient's name, ID number and address if different from the Participant's;
4. The Dentist's and/or Licensed Health Care Provider's name, tax identification number, address, degree and signature;
5. Date(s) of service(s);
6. Place of service(s);
7. Diagnostic Code;
8. Procedure Codes (describes the treatment or services rendered);
9. Assignment of Benefits (as defined in this section), signed (if payment is to be made to the Dentist, and/or Licensed Health Care Provider);
10. Release of Information Statement, signed; and
11. Explanation of Benefits (EOB) information if another plan is the primary payer.

Whether a provider or the Participant submits the claim, each claim must contain the required data elements on the standard claims forms (HCFA-1500 (revision 12/90 and later); UB92; or ADA (revision 12/90 and later)), any attachments and/or additional elements or revisions to data elements, attachments and additional elements, of which the provider or Participant has knowledge. Either a paper claim form or electronic file record must be complete, legible, and accurate.

The Plan Administrator may require attachments or other information in addition to these standard forms to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document.

Claims must be submitted individually for each Claimant. Do not staple multiple claims together.

Where to File. Completed claims should be sent to the Claims Administrator at:

TPSC Benefits
P.O. Box 2950
Tacoma, Washington 98401-2950
FAX: (253) 564-5881

The claim will be "filed" when received at the address or fax number listed above.

Failure to file correctly may result in a claim being denied or payment reduced.

TYPES OF CLAIMS

Under the Plan, there are two types of claims: Pre-Service Claims and Post-Service Claims.

Pre-Service Claims. A pre-service claim means any claim for a benefit where the terms of the Plan require advance approval of obtaining dental care. A pre-service claim may be either for urgent care or non-urgent care.

Pre-Service Non-Urgent Care Claims. A "Pre-Service Non-Urgent Care Claim" is a claim for dental benefits provided by the Plan, where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining health care. A Pre-Service Non-Urgent Care Claim will be completed and notification made to the Covered Person and his Dentist as soon as possible, but no later than 15 days after receipt of the request.

Pre-Service Urgent Care Claims. A "Pre-Service Urgent Care Claim" is any claim for dental benefits provided by the Plan with respect to which the application of the time periods for making non-urgent care determinations a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or b) 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. A Pre-Service Non-Urgent Care Claim will be completed and notification made to the Covered Person and his Dentist as soon as possible, but no later than 72 hours after receipt of the request.

Post-Service Claims. A "Post-Service Claim" is a claim for a benefit under the Plan after services or supplies have been rendered. A claim determination that involves only the payment of reimbursement of the cost of dental care that has already been provided will be made as soon as reasonably possible, but no later than 30 days from the day after receiving the claim.

Concurrent Care Claims. A "Concurrent Care" Claim is made when the participants is already receiving care, but the claim is usually a request for an extension of treatment, whether measured over a period of time or by a number of treatments, etc. If a claim is for an urgent extension of concurrent care and the request is made with 24 hours of the end of the time period or number of treatments previously approved, a determination will be made as soon as possible, but no later than 24 hours after receipt of the request. Otherwise, the normal time limits apply based on the type of claim.

Status of Claim. All submitted claims and appeals will fall into one of the categories described above. The handling of an initial claim or later appeal will be governed, in all respects, by the appropriate category of claim or appeal, and each time a claim or appeal is examined, a new determination will be made regarding the category into which the claim or appeal falls at that particular time.

EXTENSION OF TIME

The Plan will make every effort to meet the timeframes stated above. If a determination cannot be made within the stated timeframes due to circumstances beyond the control of the Plan, the Plan may unilaterally extend processing of Pre-Service Non-Urgent Care Claims and Post-Service Claims once for up to 15 days. No extension is available for Pre-Service Urgent Care Claims or an urgent extension of Concurrent Claims.

INCOMPLETE CLAIMS

If any information needed to process a claim is missing, the claim is an "incomplete claim." The Claims Administrator may request more information as provided herein.

Failure to provide requested information may result in a claim being denied or payment reduced.

Incomplete Pre-Service Urgent Care Claims. If a pre-service urgent care claim is not properly filed or incomplete, the Claims Administrator will notify the Claimant orally and/or in writing (if requested by the Claimant) as soon as possible, but not later than 24 hours, after receipt of the claim. Notice must identify the specific information needed to complete the claim.

However, the Plan Administrator must make a determination on the basis of the information provided no later than 72 hours after receipt of the claim. If the Plan has not received sufficient information to approve the claim, the Plan may deny it and issue an adverse determination notice.

Other Incomplete Claims. If a Pre-Service Non-Urgent Care or a Post-Service claim is incomplete, the Plan may deny the claim or may take a 15-day extension of time, as described above. If the Plan needs an extension of time because the Claimant failed to provide information necessary to process the claim, and the Claimant is notified of this fact, the timeframe for the Plan to make the decision is suspended from the date of that notification.

The extension notice must include a description of the missing information and specify a timeframe of at least 45 days for the Claimant to provide the missing information. Beginning either on the date the Claimant's response is received or on the date that the Claimant's response was due (if no response is received), the Plan must make a determination within the 15-day extension period. A Claimant may voluntarily agree to extend the date for determination even under circumstances where the Plan has no authority to extend the deadline.

Incorrectly Filed Claims. If a Claimant fails to follow the Plan's rules or procedures as described above, the Claimant will not have correctly filed a claim. The Plan Administrator will notify the Claimant either orally and/or in writing (if requested by the Claimant) as soon as possible.

If the claim is a pre-service urgent care claim, notice must be within 24 hours of receipt of the claim. If the claim is a pre-service non-urgent care claim, notice must be provided within five (5) days of receipt. No notice is required for incorrectly filed post-service claims.

If an adverse determination is made on the claim because of the failure to correctly file the claim, the Plan must identify the rule that was the basis for denying the claim or provide a copy of the rule to the Claimant. However, the Plan also has the discretion to deny claims at any point in the administrative process if it does not have sufficient information.

If an adverse determination is made, the Claimant may then appeal the determination.

ADVERSE BENEFIT DETERMINATIONS

An adverse benefit determination generally means “a denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit.” An adverse benefit determination includes:

1. A determination that the Covered Person is not eligible to participate in the Plan;
2. A rescission of coverage;
3. A termination of benefits;
4. A denial of benefits based on a determination that:
    a. The service or treatment is not covered (or is excluded) by the Plan;
    b. Plan limits have been met or exceeded; or
    c. The benefit is Experimental and/or Investigational or not Medically Necessary or appropriate; or
5. A reduction in benefits, such as a payment for less than the total amount of expenses submitted.

Most adverse benefit determinations are in response to a claim having been filed. However, the Plan may make an adverse benefit determination without a claim being filed (e.g., a determination that a Covered Person is not eligible).

NOTICE OF ADVERSE BENEFIT DETERMINATION

Once the Claims Administrator has reviewed the claim, the Plan must notify the Claimant in writing of its determination. The most common notice to a Claimant is an Explanation of Benefits (EOB). An EOB will be an adverse benefit determination if it meets the definition above (“a denial, reduction, or termination of, or failure to provide or make a payment (in whole or in part) for a benefit”).

Every notice of an adverse benefit determination must include sufficient information for the Claimant to appeal the adverse determination. The adverse benefit determination must include the following:

1. Information sufficient to identify the claim involved, including the date of service, the Health Care Provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes.
2. A statement of the specific reason(s) for the decision;
3. Reference(s) to the specific Plan provision(s) on which the determination is based;
4. A description of any additional material or information necessary to perfect the claim and why such information is necessary;
5. A description of the Plan procedures and time limits for appeal of the determination;
6. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
7. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant’s medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
8. In the case of Pre-Service Urgent Care Claims, an explanation of the expedited review methods available for such claims;
9. A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman; and
10. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Notification of the Plan’s adverse determination on Pre-Service Urgent Care Claims may be provided orally, but written notification shall be furnished no later than three (3) days after the oral notice.

The Claimant may call the Claims Administrator at (800) 426-9786 to discuss the adverse claim determination if there are concerns. The Claimant may also express those concerns in writing and may submit additional information that to clarify any of the circumstances that led to the adverse claim determination.

Although the Claims Administrator may accept a request for an appeal by phone or in writing, it will not consider general questions or clarifications to be an appeal unless the Claimant specifically states that he is making a formal appeal. The process for filing a formal appeal is outlined below.

RIGHT TO APPEAL

The Claimant has the right to appeal an adverse benefit determination as described above. In addition, a decision to reduce or terminate benefits for a previously-approved course of treatment is also deemed to be an adverse benefit determination. The Plan must provide the Claimant with reasonable advance notice of the reduction or termination to allow him to appeal the Plan's decision before the benefit reduction or termination takes place.

Generally, the Plan's internal appeals process provides for two appeals: an Initial Appeal of the adverse benefit determination and a Final Appeal of the determination made in the Initial Appeal.

The Claimant is entitled to a "full and fair review" of the adverse determination. "Full and fair review" means that:

1. The Covered Person will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At the Covered Person's request (and free of charge), the Covered Person will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to his claim for benefits. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Covered Person also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision-making.
3. The review of the Covered Person's claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial benefit determination.
4. Any appeal of an adverse determination will not give deference to the initial decision on the Covered Person's claim, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.
5. In deciding an appeal of any adverse benefit determination that is based on a dental judgment (including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Necessary or appropriate), the appropriate named fiduciary will consult with a dental care professional who has appropriate training and experience in the particular field of dentistry involved in the professional judgment. This dental care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this dental care professional report to the dental care professional who was consulted in connection with the adverse determination.
6. The Plan will identify dental or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the Covered Person's claim, whether or not that advice was relied upon in making the benefit determination.

INTERNAL APPEALS

The Plan has two internal appeals processes for Claimants: an Initial Appeal and a Final Appeal.

Initial Appeal of Adverse Benefit Determination. To initiate an appeal, the Claimant must submit a request to appeal to the Plan **within 180 days** of receipt of an adverse benefit determination in order. The Claimant may submit a request to appeal in writing and may provide any additional information or documentation that may support the claim. An oral request for review is acceptable for Pre-Service Urgent Care Claims and may be made by calling the Claims Administrator at (800) 426-9786 and asking the Plan to register the oral appeal.

After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Appeal of Pre-Service Urgent Care Claims. The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Claimant by telephone, fax, or other expeditious method. The Claimant will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than 72 hours after the Plan receives the request for review of the prior benefit determination.

Appeal of Pre-Service Non-Urgent Claims. For Pre-Service Non-Urgent Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.

Appeal of Post-Service Claims. For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than 30 days.

Denial of Initial Appeal. If the Covered Person's initial appeal is denied, the Plan must send him written or electronic notification that explains why the appealed claim was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;
3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
5. A statement indicating the Covered Person's right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Final Appeal of Adverse Benefit Determination. If the Covered Person is dissatisfied with the outcome of the Initial Appeal, he may make a Final Appeal. To begin the Final Appeal, the Covered Person must follow the same process required for the Initial Appeal. The Covered Person must submit a written request for appeal **within 60 days** following the receipt of the decision on the Initial Appeal.

After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Final Appeal of Pre-Service Urgent Care Claims. The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Covered Person by telephone, fax, or other expeditious method. The Covered Person will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than 36 hours after the Plan receives the second appeal.

Final Appeal of Pre-Service Non-Urgent Care Claims. For Pre-Service Non-Urgent Care Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days.

Final Appeal of Post-Service Claims. For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than 30 days.

Denial of Final Appeal. If the Covered Person's second and Final Appeal is denied, the Plan will send the Covered Person written or electronic notification that explains why the appeal was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;
3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
5. A statement indicating the Covered Person's right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

EXHAUSTION OF REMEDIES/LEGAL ACTION

A Claimant may bring a legal action to challenge a denial of benefits and to obtain appropriate legal remedies, if any. This Plan, however, requires a Claimant to exhaust all of the Plan's internal and external appeals before filing such action. If the last appeal is denied, the Claimant must then file a lawsuit no later than one (1) year after the date on that Notice of Adverse Determination, or the Claimant loses the right to bring an action on the denied claim.

CLAIMS REVIEW

Pursuant to the authority and discretion of the Plan Administrator (as described in the **PLAN ADMINISTRATOR** section below), the Plan Administrator may use its discretionary authority to utilize an independent third-party vendor (Claims Delegate) to review claims for reimbursement from medical service providers. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority to select claims for review or audit. A review is employed to identify charges that are billed in error; not Medically Necessary; in excess of Maximum Allowable Charges; or not Usual & Customary and/or Reasonable (UCR). Claims must also be consistent with any applicable term or condition stated within this Plan Document. *See* the **DEFINITIONS** section below for a detailed description of any of these terms.

To complete a comprehensive review, the Claims Delegate may access a patient's medical charts and records, in addition to medical billings, itemized statements of charges, and descriptions of the Services provided. Any additional information required for billing or medical record review will be requested directly from the service provider and/or the Claimant. If the service provider and/or the Claimant fail to provide the additional information within the designated time limits, the Claims Delegate may deny the Claim.

Upon completion of its review, the Claims Delegate will submit a report to the Plan Administrator that identifies any charges deemed to be billed in error; not Medically Necessary; in excess of Maximum Allowable Charges; not Usual & Customary and/or Reasonable (UCR); or otherwise inconsistent with any applicable term or condition stated within this Plan Document. Following review of the Claims Delegate's report, the Plan Administrator has the discretionary authority to deny a claim in whole or limit or reduce a claim to a UCR charge as provided in this Plan Document, but it may also increase the payment to the Provider, if appropriate.

If a claim is denied in whole or part, the Plan will provide the Claimant with a Notice of Adverse Benefit Determination as described above. The Claimant and/or the Facility may appeal the denial in accordance with the **CLAIMS PROCEDURES** detailed in this section.

GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefit means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Plan Administrator believes to be Medically Necessary and cost-effective. If the Plan Administrator approves payment for alternate benefits, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

AVAILABILITY OF BENEFITS

Benefits quoted to providers are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan.

For a written pre-treatment estimate, a provider of service must submit to the Claim Administrator their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the estimate of benefits.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a Physician selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan. No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

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. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person on whose behalf such payment was made.

A Covered Person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. 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 person or entity receiving an erroneous payment may not apply such payment to another expense. 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 under the Plan (including payment of future benefits for other Injuries or Illnesses) 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. 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 agrees to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. 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 or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) 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 Plan Participant(s) is 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.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. 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.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his covered dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a dependent of the Plan Participant.

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 a 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 plan Participant for any outstanding amount(s).

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition.

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants (including dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns) or a third party, where any party other than the Plan may be responsible for expenses arising from an incident, and/or other coverage is available (including, but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party).

2. Plan Participant(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 any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Plan Participant(s) agrees the Plan shall have an

equitable lien on any funds received by the Plan Participant(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 Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

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 Plan Participant(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.

Subrogation.

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(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 Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus Reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(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 Plan Participant(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; or

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

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

Right of Reimbursement.

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/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. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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, expressed 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 Plan Participant(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 Plan Participant(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 Illness, Injury, disease or disability.

Excess Insurance. If at the time of Injury, Illness, 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:

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. Workers' 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.

Separation of Funds. Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(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.

Wrongful Death. In the event that the Plan Participant(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 Plan Participant(s) and all others that benefit from such payment.

Obligations.

1. It is the Plan Participant(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 Illness, 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; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

2. If the Plan Participant(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 Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

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

Offset. Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status. In the event the Plan Participant(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.

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.

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.

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.

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

WORKER'S COMPENSATION NOT AFFECTED

This Plan does not affect any requirement for and is not in lieu of coverage provided by Worker's Compensation Insurance.

COORDINATION OF BENEFITS

The coordination of benefits provision is intended to prevent the payment of benefits that exceed Allowable Expenses. It applies when the Participant or any eligible dependent that is covered by the Plan is also covered by any other plan or plans. When more than one coverage plan exists, one Plan normally pays its benefits in full and the other plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount actually paid by the Plan will be charged against any Plan maximums.

COORDINATION OF BENEFITS DEFINITIONS

"Allowable Expenses" means the Usual & Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Coordination Order of Benefit Determinations provision (below), 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 Reasonable cash value of each service rendered—in the amount that would be payable in accordance with the terms of this Plan—shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under this Plan.

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical and prescription treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution; or
6. Any coverage under a governmental program and any coverage required or provided by any statute.

The Plan will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. A plan with no Coordination of Benefits provision will determine its benefits before a plan with a Coordination of Benefits provision.

If the plans do contain a Coordination of Benefits provision, the following rules will apply:

1. A plan that covers a person as other than a dependent will determine its benefits before a plan that covers a person as a dependent.

2. A plan that covers a person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee will determine its benefit after the plan that does not cover such person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee. If one of the plans does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

3. When a claim is made for a Dependent Child who is covered by more than one plan,

a. If there is a decree establishing financial responsibility for medical expenses of the Dependent Child (that is, a "Qualified Medical Child Support Order"), benefits as a Dependent of the parent with financial responsibility are determined before benefits as a Dependent of the parent without financial responsibility **for the duration of the decree**.

b. If there is no decree establishing financial responsibility for medical expenses of the Dependent Child, these are the rules for determining which plan pays first:

1) If the Child resides with <u>both</u> parents:

a) The benefits as a Dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that year; except,

b) If both parents have the same birthday, the benefits of the plan that has covered the parent longer are determined before those of the plan that has covered the other parent for a shorter period;

c) If the other plan does not have the rules stated in this item 3(b)(1) or (2), but instead has the rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rules in the other plan will determine the order of benefits.

2) If the Child resides with only one (1) of the parents, these are the rules for determining which plan pays first:

a) The plan of the parent with custody, then

b) The plan of the spouse of the parent with custody, then

c) The plan of the parent without custody; then

d) The plan of the spouse of the parent without custody.

4. If the above rules still do not establish an order, benefits are determined first under the plan that has covered the Employee for the longest period of time.

<u>EXCESS INSURANCE</u>

If at the time of Injury, Illness, 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.

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

1. Any primary payer besides this Plan;
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.

<u>FACILITY OF PAYMENT</u>

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, this Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision (in the section above titled **GENERAL PROVISIONS**), 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 intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her dependents.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

SECONDARY COVERAGE

This plan encourages covered persons who are eligible for secondary coverage under any other health plan to obtain such coverage. This plan will pay allowable expenses covered by these benefits. However, most benefits do not cover 100% of the incurred expenses. The covered person is then obligated to pay the difference between the plan benefit and the allowable expense. Secondary coverage may cover the difference between the actual benefit and the allowable expense, thereby reducing (or eliminating) the covered person's additional obligation.

VEHICLE LIMITATION

When medical payments are available under any vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the vehicle insurance carrier. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

PLAN ADMINISTRATION

The Plan Sponsor may appoint an individual or entity to act as the Plan Administrator and who serves at the convenience of the Plan Sponsor. The Plan Sponsor grants the greatest, legal degree of discretionary authority to interpret the Plan Document, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms. If the Plan Administrator resigns, dies, dissolves, removed from the position, or is otherwise unable to perform the duties of the Plan Administrator, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

DUTIES OF THE PLAN ADMINISTRATOR

The Plan Administrator must administer this Plan in accordance with its terms and establish its policies, practices, and procedures, and in compliance applicable federal laws. The Plan Administrator may retain the services of qualified professionals to assist in the administration of the Plan.

Specifically, the Plan Administrator may appoint and supervise a third-party administrator to pay claims for reimbursement of benefits provided by this Plan Document. The Plan Administrator shall establish a procedure for filing a claim for benefits and for Plan Participants to appeal any denial of such claim as consistent with applicable law. The Plan Administrator shall review appeals of denied claims and may uphold or reverse such decisions.

The Plan Administrator has the discretion to decide the facts and circumstances of a claim for benefits and may approve or deny a claim in whole or in part. Any reduction or increase of a claim for reimbursement shall be based on the Plan Administrator's determination of Medical Necessity, Maximum Allowable Charges, Usual & Customary and/or Reasonable (UCR), or the negotiated rate in a contractual arrangement with a provider.

The Plan Administrator's determinations of the eligibility, benefits, and reimbursement of any claim are entitled to great deference under law. Subject to the Claimant's rights to appeal as provided in the **CLAIMS PROCEDURES** section above, the Plan Administrator's determinations will be final and binding on all interested parties.

In addition, the duties of the Plan Administrator include the following:

1. To determine all questions of eligibility, enrollment, and coverage under the Plan;
2. To make factual findings;
3. To keep and maintain the Plan Documents and all other records pertaining to the Plan;
4. To perform all necessary reporting as required;
5. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
6. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
7. To perform each and every function necessary for or related to the Plan's administration.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor intends to maintain this Plan indefinitely; however, the Plan Sponsor, through its officers and directors, may amend, suspend or terminate the Plan in whole or in part at any time in its sole discretion. The Plan Sponsor shall enact any amendment, suspension or termination in accordance with the requirements of its legal status, including, but not limited to, Articles of Incorporation, Bylaws, Partnership Agreement, or other business agreement governing the Plan Sponsor's decision-making procedures and in accordance with applicable federal and state laws.

The Plan Sponsor shall provide notice of any amendment, suspension, or termination of the Plan or any of its benefits to participants. If the Plan is terminated, a Participant's claim for benefits is limited to expenses Incurred before the date of termination. The Plan Sponsor shall designate a date certain for all amendments, suspensions, or terminations to be effective.

DEFINITIONS

NOTE: The following words and phrases shall have these general meanings. ***The inclusion of a particular definition is not an indication of whether or how the Plan covers any related services or supplies.*** For specific information about your Plan, please rely on the descriptions in your Plan Document and Summary Plan Description, or contact TPSC Member Services at (800) 426-9786, ext. 210.

Accidental Injury. An injury that results accidentally or from any external, violent and anticipated causes. For instance, an unintentional bodily injury resulting from any external force and against the normal course of events can be categorized as an accidental injury.

Alveolar. Pertaining to the ridge, crest or process of bone which projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam. A mostly silver filling often used to restore decayed teeth.

Bitewing X-Ray. An x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

Bridge. A replacement for a missing tooth or teeth. The Bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Calendar Year. A period of time commencing on January 1 and ending on December 31 of the same given year.

Caries. A disease process initiated by bacterially produced acids on the tooth surface.

Claims Administrator. The person or firm retained by the Plan Administrator who is responsible for performing certain ministerial functions for the Plan.

Close Relative. The Spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's Spouse.

COBRA. Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, that provides for continuation of health care coverage after termination of employment.

Company. The Diocese of Yakima and any participating parishes or affiliates.

Composite. A tooth-colored filling, made of a combination of materials, used to restore teeth.

Cosmetic Procedure. A procedure performed solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

Covered Dental Specialty. Any group of procedures that falls under one of the following categories, whether performed by a specialist dentist or a general dentist: restorative/prosthodontic services; endodontic services; periodontic services; oral surgery; and pedodontics.

Covered Expenses. The Usual & Customary and/or Reasonable (UCR) charges for Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan.

Covered Person. Any Participant or dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

Crown. That portion of the human tooth covered by enamel.

Debridement. The gross removal of plaque and calculus that interference with the ability of the dentist to perform a comprehensive oral evaluation.

Deep Sedation. A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond. Drugs producing deep sedation may be administered intravenously (IV) or inhaled.

Dental Hygienist. A person licensed to practice dental hygiene and is practicing within the scope of their license.

Dentist. A person duly licensed to practice Dentistry by the governmental authority having jurisdiction over the licensing and practice of Dentistry in the locality where the service is rendered.

Denturist. A person who is licensed to make, fit and repair dentures and who is practicing within the scope of their license.

Dependent Coverage. Eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses Incurred for an Illness or Injury of a dependent.

Emergency. A sudden and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson, acting reasonably, to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Examples include, but are not limited to, heart attacks; cardiovascular accidents; poisonings; loss of consciousness or respiration; broken bones; automobile accidents; severe bleeding; or convulsions.

Employee. See definition of Covered Person.

Employer. See definition of Company.

Endodontics. That branch of Dentistry that deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

Enrollment Date. The earlier of: a) the first day of coverage, or b) if there is an eligibility Waiting Period for benefits, the first day of the eligibility Waiting Period.

ERISA. The Employee Retirement Income Security Act of 1974 or any provision or section thereof which is herein specifically referred to as such Act, provision or section may be amended from time to time.

Exclusions. Services and charges not covered under this Plan.

Experimental and/or Investigational. **Experimental and/or Investigational.** Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Plan Administrator to be:

1. Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
2. Not approved by the U.S. Food and Drug Administration (FDA), or other appropriate regulatory agency to be lawfully marketed for the proposed use;
3. The subject of review or approval by an Institutional Review Board for the proposed use; or
4. The subject of an ongoing Phase I, II, or III clinical trial.

Family. A Participant and his eligible dependents.

Fluoride. A substance which when topically applied or applied to drinking water is effective in resisting tooth decay.

General Anesthesia. Anesthesia that affects the whole body and usually induces a loss of consciousness and inability to feel pain. Drugs producing unconsciousness are usually administered intravenously (IV) or inhaled.

Genetic Information. Information about genes, gene products, and inherited characteristics that may derive from an individual’s laboratory tests or medical examination.

Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HIPAA Privacy Rule grants health care consumers a greater level of control over the use and disclosure of personally identifiable health information. In general, health care providers, health plans, and clearinghouses are prohibited from using or disclosing health information except as authorized by the patient or specifically permitted by the regulation. The HIPAA Standards Rule sets standards for the electronic exchange and security of a consumer’s health information.

Hospital. An institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;

2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

Illness. A bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Implant. A graft or insert set firmly onto or deeply into the Alveolar area prepared for its insertion. It may support a Crown or Crowns, a Bridge abutment, a partial denture, or a complete denture.

Incurred. The time or date a service or supply is actually provided to a Covered Person. With respect to a course of treatment or procedure that includes several stages or phases of treatment, Covered 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. Trauma or damage to the Covered Person's body from an external force.

Inlay. A dental filling shaped to the form of a cavity and then inserted and secured with cement.

I.V. Sedation. A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Lifetime. Refers to benefit maximums and is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Limitations. Restrictions such as age, period of time covered and Waiting Periods, which may limit coverage or benefits under this Plan.

Maximum Allowable Charge. The benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be:

1. The Usual & Customary and/or Reasonable (UCR) amount;
2. The allowable charge specified under the terms of the Plan; or
3. The actual billed charges for the covered services.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

The Plan has the discretionary authority to decide if a charge is Usual & Customary and/or Reasonable (UCR). The Plan will reimburse the actual charge billed if it is less than the Usual & Customary and/or Reasonable (UCR) amount.

Medically Necessary or Medical Necessity. A medical service or supply that:

1. Is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it **and**
2. Is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
    a. It is consistent with the symptoms or diagnosis and treatment of the illness or injury; **and**

b. It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility; **and**

c. It is an "appropriate" service or supply given the patient's circumstances and condition; **and**

d. It is a "cost-efficient" supply or level of service that can be safely provided to the patient; **and**

e. It is safe and effective for the Illness or Injury for which it is used.

A medical service or supply will be considered to be "appropriate" if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.
2. It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient's overall health condition.

A medical service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses Incurred in connection with the service or supply.

The fact that the Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will **not** be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

Named Fiduciary. The Company, as the Plan Administrator.

Necessary. Necessary dental treatment is defined as:

1. A condition that requires treatment; and
2. The service or supply used to treat the condition is:
   a. Required;
   b. Generally professionally accepted as the Usual & Customary and effective means of treating the condition in the United States; and
   c. Approved by regulatory authorities such as the American Dental Association.
   d. Not performed mainly for the convenience of the patient or the provider of dental services;
   e. Not conducted for research purposes; and
   f. The most appropriate level of services that can be safely provided to the patient.

All of these criteria must be met. Because a Dentist recommends or approves certain care does not mean that it is Necessary.

Nightguard/Occlusal Guard. An appliance used to treat the unconscious habit of gnashing or grinding teeth (bruxism) during the sleeping period or at times of stress.

Occlusal Adjustment. A modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the Temporomandibular Joints and the structure supporting the teeth.

Onlay. A restoration of the contact surface of the tooth that covers the entire surface.

Overdenture. A removable denture constructed over existing natural teeth or implanted studs.

Panorex X-Ray. An x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

Participant. An eligible Employee of the Company who meets the qualifications as stated in this Plan.

Participant Coverage. Coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

Periodontics. That branch of Dentistry that deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

Physician. A legally-licensed Physician or Surgeon (MD), Chiropractic Physician (DC), Dentist (DDS or DMD), Naturopathic Physician (ND), Osteopathic Physician (DO), Podiatric Physician (DPM), Advanced Registered Nurse Practitioner (ARNP), Osteopathic Physician Assistant (OPA), or Physician Assistant (PA).

Physician and/or Licensed Health Care Provider. Legally-licensed medical or dental providers permitted to perform services within the scope of their license and as provided in this Plan, including, but not limited to: Physician (as defined above), Acupuncturist (L.Ac), Certified Nurse Midwife (CNM), Registered Nurse (RN), Licensed Practical Nurse (LPN), Home Infusion Therapist or Respiratory Care Practitioners; Community Mental Health Center and Mental Health Providers (CAC, CCMH, LCSW, LMHP, MSW, PhD); Dietician (D, RD or CD) or Certified Nutritionist (CN); Audiologist, Licensed Massage Therapist (LMT), Occupational Therapist (OT), Physical Therapist (PT) or Speech Therapist (ST); Hospital, Ambulatory Surgical Center, Birthing Center; Skilled Nursing Facility, Home Health Agency, Hospice; Alcoholism Treatment Center, Drug Addiction Facility, Psychiatric Health Facility, or Residential Treatment Facility; and/or Laboratory and Radiologic Technologists.

A Physician and/or Licensed Health Care Provider shall not include the Covered Person, any Close Relative of the Covered Person, or one who resides in the same household as the Covered Person.

Plan. This Diocese of Yakima Dental Care Benefits Plan.

Plan Document. This Plan Document and Summary Plan Description.

Plan Sponsor. The Company.

Plan Administrator. The Company.

Plaque. Flat masses of bacteria and debris on tooth surfaces. Plaque may harden to create calculus (also known as tartar).

Posterior Tooth. Any one of the last five (5) teeth (pre-molars and molars) at the back of the upper (maxillary) or the lower (mandibular) jaw.

Prophylaxis. The control of dental and oral diseases by preventive measures, especially the mechanical cleaning of the teeth.

Prosthetic Appliance. A device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental expenses, shall mean any device which replaces all or part of a missing tooth or teeth.

Prosthodontics. A restorative service that is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

Reasonable and/or Reasonableness. In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Restorative. A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, Crown, Bridge or denture designed to restore proper dental function.

Scaling and Root Planing. A deep cleaning below the gum line to remove plaque and tartar and to smooth the tooth root to help the gums reattach to the tooth.

Sealant. A material applied to teeth to seal surface irregularities and prevent tooth decay.

Semi-Professional Athletics. Athletic activities for gain or pay that require an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.

Sound Natural Tooth. A tooth that is stable, functional, free from decay and advanced periodontal disease.

Space Maintainer. An appliance designed to preserve the space between teeth caused by the premature loss of a primary tooth.

Subgingival Curettage. The process of removing or cutting diseased soft tissue surrounding the tooth.

Temporomandibular Joint. The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward. A Temporomandibular Joint disorder has one or more of the following characteristics: pain in the musculature associated with the Temporomandibular Joint, internal derangements of the Temporomandibular Joint, arthritic problems with the Temporomandibular Joint, or an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

Usual & Customary (U&C). Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by 90% of providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual & Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

For a Dental Plan, "Usual & Customary" is the lesser of the provider's usual charge for the same services or supplies in the absence of insurance coverage and the charge customarily billed to private patients for the same or similar services or supplies by 90% of providers in the same geographic location (the same zip code region).

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

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

The term "Usual & Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a Physician, Dentist, Therapist, Nurse, Hospital, or Pharmacy. The Claims Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual & Customary charges may, at the Claims Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios (if applicable), average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Waiting Period. The period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan is effective.

PLAN INFORMATION

1. **Name of Plan.** Diocese of Yakima Dental Care Benefits Plan

2. **Employer Identification Number (EIN) Assigned by the Internal Revenue Service:** 91-0586353

3. **Plan Number Assigned by the Plan Sponsor:** 501

4. **Type of Plan.** Self-Funded Dental Plan

5. **Type of Administration.** Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by covered Employees, if any). The Plan is self-insured.

6. **Name, Business Address, and Telephone Number of the Plan Sponsor.**

   Diocese of Yakima

   Physical Address:[7]
   101 S 12th Avenue
   Yakima, WA 98902
   Phone: (509) 965-7117

   Mailing Address:
   PO Box 2189
   Yakima, WA 98907

7. **Name, Business Address, and Telephone Number of the Plan Administrator (Named Fiduciary).**

   Same as above.

8. **Legal Entity; Service of Process.** The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator. Name and address for service of legal process: Same as shown in #5.

9. **Name, Business Address, and Telephone Number of the Claims Administrator.**

   TPSC Benefits
   P.O. Box 1894
   Tacoma, Washington 98401-1894
   Phone: (253) 564-5850
   FAX: (253) 546-5881

10. **Plan Year.** The Plan Year is a Fiscal Year beginning November 1st through October 31st.

11. **Participating Employers.** Member Employer Parishes and Organizations of the Diocese of Yakima, including:

Diocese of Yakima Pastoral Center	Yakima, WA
Diocese of Yakima Clergy	Yakima, WA
Diocese of Yakima Seminarians	Yakima, WA
Blessed Sacrament Church	Grandview, WA
Calvary Cemetery	Yakima, WA
Christ the King Church	Richland, WA
Christ the King School	Richland, WA
Holy Apostles Church	East Wenatchee, WA
Holy Family Church	Yakima, WA
Holy Redeemer Church	Yakima, WA
Holy Rosary Church	Moxee, WA
Holy Spirit Church	Kennewick, WA
Holy Trinity Church	Goldendale, WA
Our Lady of Fatima Church	Moses Lake, WA
Our Lady of Guadalupe Church	Granger, WA

[7] Effective September 1, 2020.

11. **Participating Employers (cont'd):**

Our Lady of Lourdes Church	Selah, WA
Our Lady of the Desert Church	Mattawa, WA
Our Lady of the Snows Church	Leavenworth, WA
Sacred Heart Church	Prosser, WA
St Aloysius Church	Toppenish, WA
St Andrew Church	Ellensburg, WA
St Frances De Sales Church	Chelan, WA
St Frances X Cabrini, Division 507	Benton City, WA
St Francis Xavier Church	Cashmere, WA
St Henry Church	Grand Coulee, WA
St John the Baptist Church	Cle Ellum, WA
St John's Church	Naches, WA
St Joseph Child Care Center	Kennewick, WA
St Joseph Church	White Salmon, WA
St Joseph Church	Sunnyside, WA
St Joseph Church	Yakima, WA
St Joseph Church	Kennewick, WA
St Joseph Church	Wenatchee, WA
St Joseph School	Kennewick, WA
St Joseph School	Wenatchee, WA
St Joseph/Marquette School	Yakima, WA
St Mary Church	White Swan, WA
St Michael Archangel Church	Royal City, WA
St Paul Cathedral	Yakima, WA
St Paul Cathedral School	Yakima, WA
St Peter Claver Church	Wapato, WA
St Pius Church	Quincy, WA
St Rose of Lima Church	Ephrata, WA
St Rose of Lima School	Ephrata, WA