



Group #SIDVOCF

Plan Effective January 1, 2018

Reserve Firefighters Dental and Vision Benefits
Plan Document and Summary Plan Description

Self-funded PPO Dental & Vision Plan

Claims administered by:
HealthEdge Inc. DBA HealthEdge Administrators
5701 Truxtun Ave., Ste 100
Bakersfield, CA 93309
(866) 545-4500

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ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Plan Sponsor: **ORANGE COUNTY FIRE AUTHORITY** (herein called the "Plan", "we", "our" or "us")
Dental/Vision Group #SIDV0CF

The terms "you" and "your" are used throughout the document refer to Participants under the Plan.

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Orange County Fire Authority** (the "Company" or the "Plan Sponsor") as of March 29, 2018, hereby **amends and restates** the Orange County Fire Authority Reserve Fire Fighters Dental and Vision Benefits (the "Plan"), which was originally adopted by the Company, effective January 1, 2018. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Orange County Fire Authority

By: Debbie Casper

Name: Debbie Casper

Title: Purchasing & Materials Mgr.

Date: 3/29/18

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

About Your Coverage

This document explains the Self-Funded Dental and Vision Plan provided by **Orange County Fire Authority**. Read it closely to become familiar with your coverage. In the Plan the masculine pronouns include both masculine and feminine gender unless the context indicates otherwise.

IMPORTANT NOTICE

Benefits are payable only for expenses incurred while your coverage is in force.

No agent has the right to change the Plan or to waive any part of it.

The Plan, under which this Plan Document is issued, may be amended or canceled at any time as stated in its provisions. Such an action may be taken without the consent of or notice to any person who claims rights or benefits under the Plan.

The coverage under the Plan does not take the place of nor does it affect any requirements for coverage by Worker's Compensation or a similar type of insurance.

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Participants, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from the Plan Sponsor, or funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Plan Sponsor's general assets.

The Plan Sponsor's purpose in establishing the Plan is to provide for the payment or reimbursement of all or a portion of certain expenses for dental and vision charges. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize dental and vision costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor is required to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **Orange County Fire Authority** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Name of Plan: Orange County Fire Authority – Reserve Firefighters Program Dental and Vision Benefit Plan

Plan Sponsor: Orange County Fire Authority
Reserve Firefighters Program
1 Fire Authority Road
Irvine, CA 92602
Phone: (714) 573-6817
Fax: (714) 368-8840
Website: <https://www.ocfa.org>

**Plan Administrator:
(Named Fiduciary)** Orange County Fire Authority
1 Fire Authority Road
Irvine, CA 92602
Phone: (714) 573-6808
Fax: (714) 368-8840
Website: <https://www.ocfa.org>

Plan Sponsor ID No. (EIN): 33-0743140

Source of Funding: Self-Funded

Plan Year: January 1 through December 31

Plan Number: 501

Plan Type: Dental and Vision

Third Party Administrator: HealthEdge Inc. DBA
HealthEdge Administrators
5701 Truxtun Ave., Ste 100
Bakersfield, CA 93309
(866) 545-4500

The Plan shall take effect for each Participating Plan Sponsor on the Effective Date, unless a different date is set forth above opposite such Participating Plan Sponsor's name.

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.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the reserve status of any Participant. Nothing in this Plan Document shall be deemed to give any Participant the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Participant at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Participants.

Applicable Law

This is a self-funded benefit plan. The Plan is funded with Plan Sponsor contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

SELF-FUNDED DENTAL AND VISION ELIGIBILITY FOR COVERAGE

January 1, 2018

ELIGIBILITY FOR DENTAL AND VISION COVERAGE

PARTICIPANT COVERAGE

ELIGIBLE PARTICIPANTS – This plan has a waiting period of **30 days** of continuous service. Those Participants are eligible for coverage under this plan from the first day of the month which coincides with or next follows the day they complete the waiting period. To be eligible for Participant coverage you must be an active Participant. You must belong to a class of Participants covered by this Plan.

OTHER CONDITIONS – If you must pay all or part of the cost of Participant coverage, we will not cover you until you enroll and agree to make the required payments.

WHEN YOUR COVERAGE STARTS – Participant benefits are scheduled to start on your effective date.

You must be considered an active Participant on the scheduled effective date. You must have met all of the applicable conditions explained above and any applicable waiting period.

WHEN YOUR COVERAGE ENDS – Your coverage ends on the last day of the month in which your active service ends for any reason. Such reasons include disability, becoming a full-time member of the armed forces, leave of absence, ending of your reserve status and death.

Your coverage will also end when this Plan ends for all Participants or when this Plan is changed so that benefits for the class of Participants to which you belong ends.

CONTINUATION DURING A FAMILY LEAVE OF ABSENCE (FMLA) – FMLA does not apply to you, as Reserve Firefighters, due to your Volunteer Status.

EXTENSION OF COVERAGE DURING ABSENCE– If a Participant fails to continue in active reserve status during an approved leave of absence or disability due to sickness or injury, the Participant may be permitted to continue health coverages;

1. This extension will automatically and immediately cease on the earliest of the following date:
 - a. the end of the period for which the last contribution was paid on behalf of the Participant; or
 - b. the date of termination of this Plan.

REINSTATEMENT– If a Participant returns to active reserve status following an approved leave of absence in accordance with the Plan Sponsor's guidelines, and during the leave the Plan Sponsor discontinued paying his/her share of the cost of coverage causing coverage to terminate such Participant may have coverage reinstated. No waiting period requirement will be applied.

In accordance with Federal law, certain Participants who return to active reserve status following active duty service as a member of the United States Reserves or National Guard will be reinstated to coverage under the Plan. Neither the waiting period requirement nor any Plan limitations with reference to preexisting conditions will apply. However, this provision is intended to comply with the minimum requirements of the Veteran's Re-employment Rights Law and, if it is in conflict or incomplete in any way, such law will prevail.

DENTAL BENEFITS

DENTAL EXPENSE COVERAGE

This coverage will pay many of your dental expenses. What is paid and the terms for payment are explained below.

The Plan's Preferred Provider Organization
First Dental Health POS Network
and
The Foundation for Medical Care

This plan is designed to provide high quality dental care while controlling the cost of such care. To do this, the plan encourages a member to seek dental care from dentists and dental care facilities that belong to the First Dental Health (FDH) POS Network, which includes their EPO and PPO Provider Networks or the Foundation for Medical Care (FMC) Network.

The FDH and FMC networks are made up of providers who are required to accept the fees as shown on the coverage schedule as payment in full for covered services. Providers may bill the member for plan deductible, co-insurance, and services not covered by the plan.

Use of either dental PPO networks is voluntary. A member may receive dental treatment from any dental provider he chooses and is free to change providers at any time. However, non-participating providers may bill you for the services that exceed the coverage schedule in addition to the plan deductible, co-coverage, and services not covered by the plan.

When you enroll in this Plan, you get a dental/vision Plan ID card and information about current dental preferred providers. It is **your** responsibility to verify the provider's participation status prior to having services rendered. A Participant must present his ID card when he goes to a preferred provider. Most providers prepare necessary claim forms for the Participant and submit the forms to HealthEdge Administrators. HealthEdge Administrators will send the Participant an explanation of this Plan's benefit payments.

What is paid is based on all the terms of this Plan. Please read this material with care, and have it available when seeking dental care. Read this document carefully for specific benefit levels, deductibles, payment rate and payment limits.

BENEFITS FROM OTHER SOURCES – Other plans may furnish similar benefits. For instance, you may be covered by this Plan and a similar plan through your spouse's Plan Sponsor. If you are, HealthEdge Administrators coordinates our benefits with the benefits from these other plans. They do this, so no one gets more in benefits than the charges he incurs. Read "Coordination of Benefits" to see how this works.

DENTAL BENEFIT PROVISION – QUALIFYING FOR BENEFITS

DENTAL PRE-TREATMENT ESTIMATE – If extensive dental work is needed (where expense is expected to exceed \$250.00), the Plan Sponsor requires that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental x-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dental provider complete a statement listing the proposed dental work and charges. The form is then submitted to the Third Party

Administrator for review and estimate of benefits. The Third Party Administrator may require an oral exam or request x-rays or additional information during the course of its review.

While failure to obtain a pre-treatment estimate might reduce Plan benefits, the estimate also serves a useful purpose. First, it gives the patient and the dental provider a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known. Secondly, it offers the patient and dental provider an opportunity to consider other avenues of restorative care that might be equally satisfactorily and less costly.

Most dental providers are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

A pre-treatment estimate is not a guarantee of payment. Payment of plan benefits is subject to plan provisions and eligibility at the same time the services are actually incurred.

GROUP I, II, AND III – NON-ORTHODONTIC SERVICES – There is no deductible for Group I services. We pay for Group I covered charges at the applicable payment rate.

A benefit year deductible of \$50.00 applies to Group II and III services. Each benefit year, each Participant must have covered charges from these service groups which exceed each applicable deductible before we pay him any benefits for such charges. These charges must be incurred while the Participant is covered.

Once a Participant meets their deductible, the Plan pays for Group II and III covered charges above that amount at the applicable payment rate for the rest of that benefit year. There are different payment rates which apply to covered charges for services from a First Dental Health Provider, a Foundation for Medical Care Provider and an out of network provider.

All charges must be incurred while the Participant is covered. The Plan limits what is paid each benefit year to **\$1,500.00**. The amount paid is based on all of the terms of this plan.

GROUP IV – ORTHODONTIC SERVICES - This Plan provides benefits for Group IV orthodontic services. The Plan pays for Group IV covered charges at the applicable payment rate with no deductible. Orthodontia benefits will begin upon submission of proof that the orthodontia appliances have been installed. An initial payment is made when the active appliance is first placed. Further payments at the end of each subsequent month as claims for adjustments are received. Treatment must continue and the Participant must stay covered. There's a **\$1,000.00** lifetime maximum, to what is paid for Orthodontic services for a Participant. Orthodontic benefits will not be charged against the benefit year payment limits which apply to all other services. What is paid is based on all of the terms of this Plan.

SUMMARY OF DENTAL BENEFITS – Benefits for covered charges per Participant per Benefit Year:

Benefits for Group I Services performed by In-Network providers are paid at a rate of	100%
Benefits for Group I Services performed by Out-of-Network providers are paid at a rate of	100%

Benefits for Group II Services performed by In-Network providers are paid at a rate of	90%
Benefits for Group II Services performed by Out-of-Network providers are paid at a rate of	90%
Benefits for Group III Services performed by In-Network providers are paid at a rate of	70%
Benefits for Group III Services performed by Out-of-Network providers are paid at a rate of	70%
Benefits for Group IV Services performed by In-Network providers are paid at a rate of	50%
Benefits for Group IV Services performed by Out-of-Network providers are paid at a rate of	50%

AFTER THIS COVERAGE ENDS – Charges incurred after this coverage ends will not be paid.

SPECIAL LIMITATIONS

TEETH LOST BEFORE A MEMBER BECAME COVERED BY THIS PLAN – A Participant may have lost one or more teeth before he became covered by this Plan. Except as explained below, the Plan will not pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural lost or extracted after the Participant became covered by this Plan.

IF THIS PLAN REPLACES ANOTHER PLAN – This Plan may be replacing another plan your Plan Sponsor had with some other carrier. We do not want anyone to lose benefits when this happens. As such, the Plan pays for certain charges incurred before this Plan starts, if the Participant was covered by the old plan. The Participant must be covered by this Plan from the initial enrollment. In the first benefit year of this Plan, this Plan’s deductible will be reduced by the amount of covered charges applied against the old plan’s deductible. It is the Participant’s responsibility to provide evidence that the old plan’s deductible has been satisfied.

If a charge is made and the Plan is legally required to pay it, it will.

LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in the following list. Each service on this list has been placed in one of four groups, with no waiting periods. A separate payment rate applies to each group. Group I is made up of Preventative Services. Group II is made up of Basic Services. Group III is made up of Major Services. Group IV is made up of Orthodontic Services.

All covered dental services must be furnished by or under the direct supervision of a licensed dentist. They must be usual and necessary treatment for a dental condition.

GROUP I – PREVENTATIVE DENTAL SERVICES

1. **Exam:**
 - a. One per six month period (including any initial exam) examinations of mouth and teeth per calendar year.

2. **Cleaning:**
 - a. Cleaning and polishing of the teeth (including periodontal prophylaxis). One prophylaxis (cleaning, scaling and polishing teeth) per six month period.
3. **Fluoride:**
 - a. One topical fluoride per twelve month period.
4. **Space Maintainers:**
 - a. fixed appliances used to prevent abnormal movement of teeth as a result of premature loss.
5. **Full Mouth/Panoramic X-rays:**
 - a. one diagnostic x-rays - full mouth (full mouth series of at least 14 films including bitewings, if needed) or panoramic, limited to once per 24-month period
6. **Bitewings:**
 - a. one series per six month period.
7. **Periapical X-rays:**
 - a. periapical x-rays; 14 films or more in one visit are considered full mouth x-rays
8. **Emergency Palliative:**
 - a. only payable if billed by itself or with x-rays per date-of service.

GROUP II – BASIC DENTAL SERVICES

1. **Fillings:**
 - a. fillings of amalgam, silicate, acrylic, synthetic porcelain and composite filling materials (restorations mesiolingual, distolingual, mesiobuccal and distobuccal surfaces considered single surface restorations);
 - b. pin retention of fillings
2. **Endodontic treatment** of disease of the tooth, pulp, root, and related tissue, as follows:
 - a. root canal therapy (not covered, if pulp chamber was opened before covered);
 - b. pulpotomy;
 - c. apicoectomy; and retrograde fillings
3. **Extractions:** Simple and Surgical. Oral surgery , including post-operative care for:
 - a. removal of teeth, including impacted teeth;
 - b. extraction of tooth root,
 - c. alveolectomy, alveoplasty, and frenectomy;
 - d. excision of periocoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy;
 - e. reimplantation or transplantation of a natural tooth; and
 - f. excision of a tumor or cyst and incision and drainage of an abscess or cyst; and
 - g. bone augmentation procedures such as grafting.
4. **Pathology**, limited to:
 - a. diagnostic laboratory services performed to assist in the diagnosis of oral disease.
5. **Periodontic services**, limited to:
 - a. root scaling and planing,
 - b. occlusal adjustment, performed with covered surgery;
 - c. gingivectomy, gingival curettage, and mucogingival;
 - d. osseous surgery including flap entry and closure; pedical or free soft tissue grafts
6. **Stainless steel crowns**
7. **Antibiotic Therapy:**
 - a. antibiotic injections (i.e. Arestin) administered by Dentist
8. **General Anesthesia –**
 - a. when Medically Necessary and administered in connection with oral surgery or dental surgery. (Not including separate charges for pre-medication, local anesthesia, or conscious sedation.)

9. **Specialty Consultation:**

- a. only payable if billed by itself or with x-rays per date-of service.

GROUP III – MAJOR DENTAL SERVICES

1. **Restoration services**, limited to:

- a. gold or porcelain inlays, onlays, and crowns for tooth with extensive cavities or fracture that is unable to be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material;
- b. replacement of existing inlay, onlay, or crown, after 5 years of the restoration initially placed or last replaced. Subject to dental review, this limitation will not apply if replacement is necessary due valid unforeseen circumstance of functioning natural teeth while covered;
- c. recementing inlays, onlays and crowns;
- d. post and core;
- e. crown build-up for non-vital teeth

2. **Prosthetic services**, limited to:

- a. initial placement of dentures or fixed bridgework (including bonded retainer/fixed bridge), when denture or bridgework includes replacement of a natural tooth extracted or lost while covered under the Plan.
- b. replacement of dentures or fixed bridgework that cannot be repaired after 5 years from the date of placed or last replaced;
- c. addition of teeth to existing partial denture, only if to replace natural teeth extracted or lost while covered under the Plan.
- d. repair, relining or rebasing of full or partial dentures and fixed bridgework, only when provided more than 6 months following installation. Allowed only once in any 24 month period.
- e. recementing bridges.

GROUP IV – ORTHODONTIC SERVICES

- 1. Services or supplies for the correction of bite or malocclusion or for the alignment or repositioning of teeth to include:
 - a. initial consultation, study models, x-rays and other diagnostic services;
 - b. comprehensive full-banded orthodontic treatment;
 - c. active appliance therapy, including fixed or cemented appliances for tooth guidance and fixed or cemented appliances to control harmful habits;
 - d. retainers

DENTAL EXCLUSIONS

DENTAL EXPENSES NOT COVERED

This Plan covers services and procedures as described in the Summary of Dental Benefits section. Your coverage, under this Plan, **does not** cover any miscellaneous separate expense not considered a covered service or procedure.

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

- 1. For customized prosthetics, including precision or semi-precision attachments, overdentures and associated procedures.
- 2. Crowns placed for the purpose of periodontal splinting.
- 3. For cosmetic dentistry, except when necessitated by an Accidental Injury and then limited to services rendered while the individual is covered under the Plan and within two years following the accident.

4. Analgesia - separate charges for pre-medication, local anesthesia, or conscious sedation.
5. For implants or the removal of implants.
6. For sealants
7. For appliances, including, night guards and athletic mouthguards;
8. For myofunctional therapy, such as muscle training therapy, tongue thrust or training to correct or control harmful habits.
9. Discoloration treatment, such as bleaching/whitening of the teeth.
10. Congenital or Developmental Conditions, such as the treatment of congenital (hereditary) or developmental (following birth) malformations.
11. Excess care, including services which exceed those necessary to achieve an acceptable level of dental care. If the Plan Sponsor determines that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, benefits will be provided for the least costly procedure(s) which would produce a professionally satisfactory result.
12. For the replacement of dentures, bridges, inlays, onlays or crowns that can be repaired or restored to normal function.
13. For replacement of a prosthetic or any other type of appliance which has been lost, misplaced or stolen; and for
 - a. replacement and/or adjustment of retainers;
 - b. precision or semi-precision attachments; or
 - c. duplication of prosthetic devices or appliances.
14. For oral hygiene instructions, including;
 - a. education or training in and supplies used for dietary or nutritional counseling;
 - b. personal oral hygiene instruction;
 - c. plaque control;
 - d. prescription or take-home fluoride; or
 - e. supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks, dental floss and mouthwashes.
15. For acid etch.
16. For diagnostic photographs.
17. For services rendered by other than a Dentist (D.D.S. or D.M.D) or a dental hygienist or x-ray technician under the supervision of a Dentist.
18. For services not completed by the end of the month in which coverage ends, unless continuation of coverage has been requested and accepted by Us.
19. For procedures that are begun, but not completed. (**payment is based on seat date**)
20. For services and treatment provided without charge or for which there would be no charge in the absence of insurance.
21. For a condition covered under any Worker's Compensation Act or similar law.
22. For services that are applied toward satisfaction of a Deductible, if any.
23. For services that are generally considered by the dental profession as experimental or investigational.
24. For the treatment of cleft palate and anodontia.
25. For services or supplies payable under any medical expense plan.
26. Prior to the date the Participant is covered under the Plan.
27. For the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJD)/Maxillofacial Surgery, including;
 - a. Any charges for jaw augmentation or reduction procedures;
 - b. or procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome, including the correction of abnormal positioning and relationship of teeth.
28. For Vertical Dimension;
 - a. Procedures which are performed solely to increase vertical dimension.
29. For hospital services.

30. If you voluntarily end Your insurance outside of open enrollment, You will not be eligible to re-enroll for a period of 1 year after the date Your coverage first ended.
31. Charges for infection control, sterilization, and waste disposal.

(See also, GENERAL EXCLUSIONS section)

VISION BENEFITS

VISION EXPENSE COVERAGE

PAYMENT RATES SUMMARY OF VISION BENEFITS – Benefits for covered charges per Participant per Benefit Year:

Maximum Allowances	
Deductible	None
Eye Exams	\$50.00/One exam every calendar year
Frames	\$75.00/One pair every calendar year
Lenses, per pair	One pair every calendar year
Single Vision	\$70.00
Bifocal	\$80.00
Trifocal	\$120.00
Lenticular / Aphakic Monofocal	\$150.00
Contacts in lieu of glasses :	Up to \$300.00 when medical necessary Up to \$120.00 for convenience

VISION BENEFITS AND LIMITATIONS

CHOICE OF PROVIDERS – Visit any provider; Participant is responsible for any fees over the above listed Summary of Vision Benefits.

ELIGIBLE EXPENSES – We will pay for Eligible Expenses You incur while covered under the Plan.

1. Plan will pay up to 100% of the Allowance. Participant is responsible for all charges exceeding the Maximum Allowance.
2. **Vision Examinations** - Each Participant is entitled to a complete analysis of the eyes and related structures to determine vision problems and other abnormalities. We will cover such Service once per calendar year.
3. **Materials:**
 - a. **Lenses** - We will pay for new prescription for Standard Lens, one pair per calendar year.
 - b. **Frames** - We will pay for new Standard Frames, one pair per calendar year.
 - c. **Contact Lenses** - When a Participant chooses contact lenses due to convenience or medically necessary, payment will be IN LIEU OF ALL OTHER MATERIALS BENEFITS. Contact lenses are covered to the Maximum Allowance in a 12 month period. The lens allowance equals 2 lenses. If only 1 lens is needed the allowance will be ½ the lens allowance.
 - i. Contact lenses are medically necessary:
 1. when cataract surgery has been received;
 2. when visual acuity cannot be corrected to 20/70 in the better eye except by use of contacts;
 3. when necessitated by anisometropia;
 4. or certain conditions of keratoconus;
 5. or other medically necessary conditions.
4. What is covered:
 - a. The amounts shown are Maximum Allowances. The actual amount We pay for any service or material will be the lesser or the amount listed in the Summary of Vision Benefits for such rendered and/or materials purchased, or the actual amount

charged. There is no assurance that the amount listed in the Summary of Vision Benefits will be sufficient to pay the full cost of the service rendered or the materials selected.

5. Limitations - In no event will payment exceed the lesser of:
 - a. the actual cost of covered Services or Materials; or
 - b. the limits of the Plan, shown in the Summary of Vision Benefits.

VISION EXCLUSIONS

The following are not covered by this Plan.

1. Medical or Surgical Treatment of the eyes.
2. No prescription change – glasses purchased when the lens prescription has not changed.
3. Non-professional care – Visual examination performed other than by a licensed ophthalmologist or optometrist.
4. Orthoptic or vision training and any associated supplemental testing.
5. Sub-normal Vision Aids or Non-Prescription Lenses – Lenses which do not correct refractive error (plano lenses) or which are not obtained upon prescription by an ophthalmologist, optometrist or optician.
6. Any material furnished as the result of any eye refraction which began before the individual's effective date of coverage under the Plan.
7. Radial Keratotomy – Surgery to correct refractive error.
8. Sunglasses – Sunglasses (tint other than No 1 or 2) or photosensitive lenses.
9. Lens Coatings
10. Two pair of glasses, in lieu of bifocals or trifocals.
11. Any eye examination, or any corrective eyewear, required by an Plan Sponsor as a condition of reserve status, including but not limited to safety lenses or goggles
12. Photo-chromatic lenses
13. Services rendered or Materials purchased outside the U.S. or Canada, unless:
 - a. the Participant resides in the U.S. or Canada; and
 - b. the charges are incurred while on a business or pleasure trip.
14. Charges in excess of the Maximum Allowance for the Service or Materials.
15. Charges incurred after:
 - a. the Plan ends; or
 - b. the Participant's coverage under the Plan ends, except as stated in the Plan.
16. Experimental or non-conventional treatment or device.
17. Spectacle lens treatments or "add-ons".
18. Lost or broken Materials, except when replaced at normal intervals when Services are available.

(See also, GENERAL EXCLUSIONS section)

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

1. For completion of a claim form.
2. Claims received after 12 months from the date of service.
3. Criminal Activities – Any injury resulting from or occurring during the Participant's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance or taking part as a principal or as an accessory in illegal activities or an illegal occupation.
4. For charges in excess of the applicable Network fee schedule for dental and vision services or supplies.
5. For broken appointments – expenses incurred for failure to keep a scheduled appointment
6. No Charge/No legal requirement to pay – Services for which not charge is made or for which an Participant is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).
7. Not Listed Services or Supplies – Any services, care or supplies not specifically listed in the Plan Document as Eligible Expenses are NOT covered under the Plan.
8. Other Coverage – Services or supplies for which an Participant is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).
9. Outside United States – Charges incurred outside of the United States if the Participant traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.
10. Postage, Shipping, Handling Charges, Etc. – Any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator, Interest or financing charges.
11. Prior Coverages – Services or supplies for which the Participant is eligible for benefits under the plan which this Plan replaces.
12. Services rendered by a close relative, including a Participant's spouse, children, parents, brother and sister.
13. Self-Inflicted Injury – Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction which occurred while sane or insane and regardless of whether the Covered Person was aware of or in control of his or her actions.
14. Telecommunications – Advice or consultation given by or through any form or telecommunication.
15. For services in connection with war or any act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country or combination of countries.
16. Any injury or illness when covered under any Workers' Compensation or similar law, or which is work-related.

COORDINATION OF BENEFITS

If any person under this Plan is also covered under one or more other plans, the benefit under this Plan will be coordinated with benefits payable under all other plans.

This coordination will apply in determining the benefits payable for any Claim Period if the sum of:

1. the benefits that would be payable under this Plan in the absence of coordination; and
2. the benefits that would be payable under all other plans without provisions for coordination in those plans would exceed such benefits.

Except as provided in the following paragraph, when Coordination of Benefits applied to the benefits payable for any Claim Period, the benefits that would be payable for Eligible Expenses under this Plan in the absence of Coordination of Benefits will be reduced to the extent necessary so that the sum of those reduced benefits and all the benefits payable for those Eligible Expenses under all other plans will not exceed the total of those Eligible Expenses. Benefits payable under all other plans include the benefits that would have been payable had a claim been properly made for them.

The rules establishing the order of benefit determination are:

1. A plan on which the person for whom a claim is made is a primary member will be determined before the benefits of a plan covering such person as a dependent.
2. The benefits of a plan covering a Participant who is neither laid-off nor retired (or as that Participant's dependent) are determined before those of a plan which covers that person as a laid-off or retired Participant (or as the Participant's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule 2 is ignored.
3. If neither of the above rules determines the order of benefits, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before the benefits of a plan covering the person the shorter period of time.

If this Plan is responsible for secondary coverage for Eligible Expenses, it will not deny coverage or payment of the amount owed as secondary payer solely on the basis of the failure of another group contract, which is responsible as the primary payer, to pay for such Eligible Expenses. This will not require this Plan to pay the obligation of the primary payer.

For the purposes of administering the above provisions of the Plan or any similar provisions of other plans, HealthEdge Administrators may, without consent or notice to any person, release to or obtain from any other coverage, company, organizations or person, any information concerning any individual which We consider necessary within the Health Insurance Portability and Accountability Act (HIPAA) privacy and security guidelines.

Any person claiming benefit under this Plan will furnish HealthEdge Administrators with any information necessary.

Whenever payments have been made by the Plan, for Eligible Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of the above provisions, they will have the right to recover the excess from one or more of the following: (1) other coverage companies, (2) other organizations, or (3) persons to or for whom payments were made.

BENEFITS SUBJECT TO COORDINATION. All benefits provided under the Plan are subject to coordination.

DEFINITIONS. The following definitions apply only to this Coordination of Benefits section:

1. The term “plan” means coverage providing dental benefits or services by:
 - a. group or blanket coverage except school accident coverage; or
 - b. labor-management trustee plans, union welfare plans, Plan Sponsor organization plans or Participant benefit plans.

“Plan” will be construed separately for a policy, contract, or other arrangement for benefits or services that reserves, the right to take the benefits or services of their plans into consideration in determining its benefits, or separately for that portion which does not reserve the right.

1. The term “Eligible Expense” means any necessary, reasonable, and customary item of expense all or part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Eligible Expense and a benefit paid.
2. The term “Claim Period” means a calendar year or portion of a calendar year for a claim on a person covered under this Plan.

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. to administer the Plan in accordance with its terms;
2. to determine all questions of eligibility, status and coverage under the Plan;
3. to interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. to make factual findings;
5. to decide disputes which may arise relative to a Participant's rights and/or availability of benefits;

6. to prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. to keep and maintain the Plan documents and all other records pertaining to the Plan;
8. to appoint and supervise a Third Party Administrator to pay claims;
9. to delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
10. to perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Participants with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for covered expenses incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered Participants.

Summary of Material Modification (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Participants of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within 210 days after the close of the Plan Year in which the changes became effective.

Misuse of Identification Card

If a Participant permits any person to use any identification card issued, the Plan Sponsor may give Participant written notice that his coverage will be terminated at the end of 31 days from the date written notice is given.

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, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical, dental or vision payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. 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 dental or vision 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 Participant(s) agrees the Plan shall have an equitable lien on any funds received by the 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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the 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 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 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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the 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 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, dental, vision, disability or other benefit payments, and school insurance coverage;

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The 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 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, dental, vision, disability, or other expenses. If the 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 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 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 sickness, injury, disease or disability.

Excess Insurance

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

The Plan's benefits shall be excess to:

1. the responsible party, its insurer, or any other source on behalf of that party;
2. any first party insurance through medical, dental, or vision 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, dental, vision, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of dental and/or vision benefits by the Plan:
 - a. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b. to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
2. If the 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 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 Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

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

Minor Status

1. In the event the 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.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of dental and/or vision 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.

MISCELLANEOUS PROVISIONS

Applicable Law

The Plan is funded Plan Sponsor contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

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

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement.

Fraud

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire family unit of which the Participant is a member.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to

enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Plan Sponsor and the amount to be contributed (if any) by each Participant.

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.

Notwithstanding any other provision of the Plan, the Plan Administrator'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 Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Plan Sponsor and eligible Participants shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims incurred after the termination date of the Plan.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, 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 amount, and any future benefits payable to the Participant. See the Recovery of Payments provision for full details.

Statements

All statements made by the Company or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits

under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

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

Protection Against Creditors

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 the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his/her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such 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. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

Unclaimed Self-Insured Plan Funds

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

HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling (866) 545-4500 or visiting www.healthedgeinc.com.

GLOSSARY

This Glossary defines the italicized terms appearing in the Plan.

Active Appliance means an appliance like braces, used on orthodontic treatment to move teeth.

Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Allowable Expenses means the Usual and Customary charge for any Dentally Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some other plan pays first in accordance with the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the 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.

Appliance means any dental device other than a prosthetic device.

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

Benefit Year with respect to this Plan's dental and vision benefits, means a 12 month period which starts on January 1st and ends on December 31st of each year.

Calendar Year – The period of time commencing at 12:01 a.m. on January 1 of each year and ending at 12:01 a.m. on the next succeeding January 1.

Claimant – Any Participant for whom a claim is submitted for benefits under the Plan.

Clean Claim – A ***Clean Claim*** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Dental Necessity

and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

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

Close Relative means: (a) a Participant's spouse, children, parents, brothers and sisters; and (b) any other person who is part of a Participant's household. We do not pay for service and supplies furnished by close relatives.

Covered Expense(s) means a Usual and Customary fee for a Reasonable, Dentally Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Dental Benefits and the Summary of Vision Benefits, and as determined elsewhere in this document.

Dental Necessity, Dentally Necessary, and similar language refers to services recommended by the treating provider and if all of the following are met:

1. The purpose of the service, supply or intervention is to treat a dental condition;
2. It is the appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply or intervention is known to be effective in improving health outcomes;
4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

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

Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he practices; and (b) provides services which are within the scope of his license or certificate and covered by this Plan.

Eligible Expense(s) – Expense which is (1) covered by a specific benefit provision of the Plan Document and (2) incurred while the person is covered by the Plan.

Participant means a member of the Orange County Fire Authority – Reserve Firefighters Program.

Plan Sponsor means Orange County Fire Authority – Reserve Firefighters Program.

Enrollment Period means the 31 day period which starts on the date that you first become eligible.

Fiduciary – A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan Trustees, if any.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

Incurred — A Covered Expense is “Incurred” on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, 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 with respect to this Plan’s dental or vision expense insurance means all damage to a Participant’s mouth due to an accident, and all complications rising from that damage. The term injury does not include damage to teeth, appliances or prosthetic devices which results from chewing or biting food or other substances.

Maximum Amount and/or Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed the following:

1. the Usual and Customary amount;
2. the allowable charge specified under the terms of the Plan;
3. the Reasonable charge specified under the terms of the Plan;
4. the negotiated rate established in a contractual arrangement with a Provider; or
5. the actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Dentally Necessary and Reasonable service.

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.

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. It includes: (a) diagnostic services; (b) the treatment Plan; (c) the fitting, making and placement of an active appliance; and (d) all related office visits, including a retainer.

Participant means any Participant who is eligible for benefits under the Plan.

Plan means Orange County Fire Authority – Reserve Firefighters Program Dental and Vision Benefit

Prosthetic Device means a device which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, pontics, occlusal guards and inlays/onlays.

Reasonable and/or **Reasonableness** means 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's error or mistake. 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 evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. 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.

The Plan Administrator 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.

Third Party Administrator means the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

Uniformed Services means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

Usual and Customary (U&C) means 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 providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for dental or vision services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other dental or vision 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 dental and/or vision 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 and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

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

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

CLAIMS PROCEDURES

Present your identification card to the provider of services and they will submit your claim to the Third Party Administrator for processing.

PLAN ADMINISTRATOR

ORANGE COUNTY FIRE AUTHORITY
1 FIRE AUTHORITY ROAD
IRVINE, CA 92602

THIRD PARTY ADMINISTRATOR

FOUNDATION FOR MEDICAL CARE OF KERN COUNTY
HEALTHEDGE ADMINISTRATORS, INC.
5701 TRUXTUN AVE., STE 100
BAKERSFIELD, CA 93309

CUSTOMER SERVICE TELEPHONE NUMBER

(661) 616-4848
(866) 545-4500 toll free
(661) 616-4889 fax

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. For the purposes of this section, "Claimant" shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

The availability of health benefit payments is dependent upon Claimants complying with the following:

Dental and Vision Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of dental or vision services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine

the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Claimant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a Final Adverse Benefit Determination. If the Claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 180 days of the date charges for the service(s) and/or supplies were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Claims filed later than that date shall be denied.

A Pre-service claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. the date of service;
2. the name, address, telephone number and tax identification number of the provider of the services or supplies;
3. the place where the services were rendered;
4. the Diagnosis and procedure codes;
5. the amount of charges, which reflect any applicable PPO re-pricing ;
6. the name of the Plan;
7. the name of the covered Participant; and
8. the name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan. Claims should be sent to:

HealthEdge Inc. DBA HealthEdge Administrators
5701 Truxtun Ave., Ste 100
Bakersfield, CA 93309
(866) 545-4500

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:
 - a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
 - b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 72 hours after receipt of the claim.
 - c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
 - i. the Plan's receipt of the specified information; or
 - ii. the end of the period afforded the Claimant to provide the information.
 - d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.
2. Pre-service Non-urgent Care Claims:
 - a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
 - b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than five days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the

date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:

- a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
- b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
- c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service non-urgent claim or a Post-service claim).
- d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:
 - i. Notification to Claimant 30 days
 - ii. Notification of Adverse Benefit Determination on appeal 30 days

4. Post-service Claims:

- a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
- b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
- c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.
 - i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- iii. Extensions – Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

5. Calculating Time Periods:

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. a reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
5. a description of the Plan's review procedures and the time limits applicable to the procedures, following an Adverse Benefit Determination on final review;
6. a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
7. the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);
9. in the case of denials based upon a medical judgment (such as whether the treatment is Dentally Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request; and
10. in a claim involving urgent care, a description of the Plan's expedited review process.

APPEAL PROCEDURES

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. at least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. that, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
8. that a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; and
9. that a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

Requirements for Appeal

The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

HealthEdge Inc. DBA HealthEdge Administrators
5701 Truxtun Ave., Ste 100
Bakersfield, CA 93309
(866) 545-4500

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

1. the name of the Participant/Claimant;
2. the Participant/Claimant's social security number;
3. the group name or identification number;
4. all facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;
5. a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

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

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal;
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal;
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service; and
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
3. a reference to the specific portion(s) of the plan provisions upon which a denial is based;
4. the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request); A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits;
5. any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request;
6. a description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
7. a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
8. a description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Claimant's right to bring a civil action, following an Adverse Benefit Determination on final review;
9. in the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request; and
10. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Decision on Review

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

2. a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
 - a. the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - b. the Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - c. the Claimant has exhausted the Plan’s internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the interim final regulations;
 - d. the Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Participant Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
4. Reversal of Plan’s decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination,

the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. **Request for expedited external review.** The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
 - a. an Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal; or
 - b. a Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.
2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the Claimant of its eligibility determination.
3. **Referral to Independent Review Organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. **Notice of final external review decision.** The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the Claimant and the Plan.

Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the

information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Claimant shall not be recognized as a designation of the provider as an authorized representative. Assignment and its limitations under this Plan are described below.

Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an Assignment of Benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or provider who provided the care and/or supplies for which payment is to be made – regardless of whether an Assignment of Benefits occurred.

Assignments

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

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

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

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

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

Non U.S. Providers

A provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical, dental or vision care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of Benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If Assignment of Benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

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 Claimant on whose behalf such payment was made.

A Claimant, 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

Claimant 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 Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, provider or other person or entity to enforce the provisions of this section, then that Claimant, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) 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 Claimant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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 years after the date such coverage commences;
4. with respect to an ineligible person;
5. in anticipation of obtaining a recovery if a Claimant 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.

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

Medicaid Coverage

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

Limitation of Action

A Claimant cannot bring any legal action against the Company or the Third Party Administrator to recover reimbursement until 90 days after the Claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the Claimant's claim have been completed. If the Claimant wants to bring a legal action against the Company or the Third Party Administrator, he/she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Third Party Administrator.

A Claimant cannot bring any legal action against the Company or the Third Party Administrator for any other reason unless he/she first completes all the steps in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Third Party Administrator he/she must do so within three years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Third Party Administrator.