PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR

Beus O'Connor McGroder

DENTAL PLAN
EFFECTIVE JANUARY 1, 2024

For assistance in a non-english language, please call 866-768-9683.

Para obetener asistencia en Español, por favor llame al número arriba.

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Introduction

Welcome to the Beus O'Connor McGroder, PLLC Dental Plan. This document explains the operation of your dental plan. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain preventive, basic, and major dental expenses. Please call **866-768-9683** with any questions regarding this document.

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees and to provide payment for certain health benefits, in accordance with the terms and conditions described herein. This is the final version of your benefits. No oral interpretations can change this plan.

The purpose of this Plan Document is 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 hospital or medical charges.

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. No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Not a Contract of Employment
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time.

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). 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 Covered Persons' rights; and to determine all questions of fact and law arising under the Plan. The Plan Administrator reserves the right to amend any part of the plan or terminate the Plan at any time.

Claims Administrator Is Not a Fiduciary
A Claims Administrator is not a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

Type of Administration
The Plan is a self-funded group health plan and the administration is provided through a third-party Claims Administrator.

Plan Contributions & Funding
Premiums are funded by contributions by the Employer and covered Employees. The Plan Administrator reserves the right to change the level of Employee contributions. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. Employer funds are provided out of the Employer's general assets.

Summary of Eligibility, Benefits, and Exclusions

For full details, please see the sections entitled Eligibility, Effective Date and Termination, Schedule of Benefits and Exclusions.

ELIGIBILITY	
Full Time Requirements	20 hours per week
Waiting Period	First day following 14 days of continuous employment (15th day)
Dependent	1. Spouse 2. Employee's Child (under 26, unless disability exception applies)
Employee Termination	Last day of the month when no longer under an eligible class.
Dependent Termination	Last day of the month when no longer under an eligible class.
Rehired Employees	A terminated Employee who is rehired after 6 months will be treated as a new hire.

DEDUCTIBLE	
Deductible Year Runs January 1st to December 31st	
Individual Deductible: $100	**Annual Maximum:** $3,500 per person **Orthodontics Lifetime Maximum:** $3,500 per person
Family Deductible: $200	

COINSURANCE (% indicates Covered Person responsibility)	
SERVICE TYPE	**COINSURANCE**
Preventive & Diagnostic	0%
Basic Restorative Care	20%
Major Restorative	50%

Eligibility, Effective Date and Termination

If you have any questions regarding eligibility, please call **866-768-9683**.

NOTE: Failure to adhere to the Eligibility or Enrollment Requirements explained below may result in delay of coverage or no coverage at all.

ELIGIBILITY

Eligibility Requirements for Employee Coverage.

Each full-time Non-Variable Hour Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day following completion of 14 days of continuous employment (15th day), provided the Employee has begun work for the Employer. If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work.

Each Variable Hour Employee who has averaged 30 Hours of Service per week or 130 Hours of Service per month will become eligible for coverage under this Plan with respect to himself or herself upon completion of a complete Measurement Period. Coverage shall begin on the first day of the Stability Period. Measurement and Stability Periods are defined by the Employer.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the effective date of this Plan. Any Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Waiting Period of this Plan.

Eligible Classes of Dependents. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. A Dependent is any one of the following persons:

(1) An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, "marriage or married" means a legal union;

(2) An Employee's Child who is less than 26 years of age; and

(3) An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age stated above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age stated above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age stated above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two-year period, the Plan may require such proof, but not more often than once each year.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. This enrollment remains in force for the full coverage period until the next open enrollment and cannot be dropped without a qualifying event.

OPEN ENROLLMENT

Approximately 30 days before the end of the current Plan Year, and for 15 days following the effective date of the subsequent plan year (the annual open enrollment period), covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

TIMELY OR LATE ENROLLMENT

(1) Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

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

(2) Late Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees will not be eligible for coverage until the next annual Open Enrollment Period.

SPECIAL ENROLLMENT RIGHTS

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

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

(1) Individuals losing other coverage. An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment;

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated; and

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

Effective Date. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee if:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period); and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his or her eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

Effective Date for Dependents. The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, as of the date of marriage (proof of marriage may be required); or

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

In addition, an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a Special Enrollment right because the dependent lost eligibility for other coverage.

Special Enrollment Rights under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

If an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage under the Plan will take effect for an eligible Active Employee when the Employee satisfies all eligibility and enrollments requirements of the Plan, including satisfying the Waiting Period.

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

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

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, including but not limited to making a fraudulent Claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, Claims paid will be offset from this amount. The employer reserves the right to collect additional monies if Claims are paid in excess of the Employee's and/or Dependent's paid contributions.

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

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section entitled Continuation Coverage Rights under COBRA for a complete explanation):

(1) The date the Plan is terminated;

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA);

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

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

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

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active Full-Time Employment ceases due to disability, leave of absence or layoff. This continuance will end at the earlier of:

For disability leave only: The date the Employer ends the continuance or at the exhaustion maximum period available under FMLA and/or COBRA.

For leave of absence or layoff only: The date the Employer ends the continuance or at the exhaustion of maximum period available under FMLA and/or COBRA.

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

Continuation during Family and Medical Leave. During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

If an Employee takes a leave of absence that qualifies as a family or medical leave under the Family Medical Leave Act (FMLA) of 1993, the Employee should contact the Plan Administrator in order to discuss his or her continued participation in the Plan during the leave. The Employee must continue to pay for his or her health, dental, disability and any health care expense reimbursement benefits via a method mandated by the Employer. Failure by the Employee to make timely payments will result in the discontinuance of coverage for the Employee and any dependents.

Rehiring a Terminated Employee. A terminated Employee who is rehired after 6 months will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage, going from part time to full time or from temporary to permanent employment. This Employee does not have to satisfy the employment Waiting Period or Pre-Existing Conditions provision.

Employees on Military Leave (USERRA). Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 18-month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. See the section entitled Continuation Coverage Rights under COBRA for a complete explanation):

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

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA);

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA);

(4) On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA);

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

(6) The earliest date the Dependent has a Claim that is denied in whole or in part because it meets or exceeds an annual limit on non-Essential health benefits; or

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

Schedule of Benefits

Call 866-768-9683 to verify eligibility for Plan benefits before the charge is Incurred.

DEDUCTIBLE

The Deductible is an amount of Covered Expenses for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the Deductible shown in the Schedule of Benefits. Once the deductible has been met, the Plan will begin paying benefits in accordance with the Schedule of Benefits.

ANNUAL MAXIMUM

The Annual Maximum is the amount the Plan will pay for Covered Expenses per Covered Person each year. Any accumulation of charges for Covered Expenses beyond the Annual Maximum will be the responsibility of the Covered Person.

COINSURANCE

Coinsurance. A coinsurance is an amount of money that the Covered Person responsible for, as listed in the Schedule of Benefits. The coinsurance is expressed as a percentage. The remaining percentage that is not paid by the Covered Person is paid by the Plan. Some services may require a coinsurance payment from the Covered Person.

CONDITIONS OF COVERAGE

All benefits under this Plan must satisfy some basic conditions for the Plan to provide payment. The following conditions apply:

Alternate Procedures. The Plan only provides benefits for the most cost-effective treatment of a dental condition which provides a professionally acceptable result as determined by national standards of dental practice.

Usual and Customary Charges. The Plan provides benefits only for covered expenses that are equal to or less than the Usual and Customary Charge in the geographic area where services or supplies are provided. Any amount that exceeds the Usual and Customary Charge is not recognized by the Plan for any purpose.

Dental Care Providers. The Plan provides benefits only for covered services rendered by a Dentist or Dental Hygienist as those terms are specifically defined in the Definitions sections.

MEDICAL BENEFITS SUBJECT TO PLAN ADMINISTRATOR DETERMINATIONS

All benefits described in this Schedule are subject to the exclusions and limitations described in this Plan Document including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Customary; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the section entitled Definitions.

Reduction or Denial of Benefits. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, and timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of Claims or lack of coverage.

When Claim is Incurred. An expense for a service or supply is Incurred on the date the service or supply is furnished. The Plan will pay for expenses Incurred while you are a Covered Person. It does not cover expenses Incurred before coverage began or after coverage terminated.

Termination or Amendment. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Expenses Incurred before termination, amendment or elimination of any particular benefit or aspect of the Plan.

INFORMATION AND RECORDS

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proof that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information within 30 days of when requested, it may delay or deny payment of Benefits. This may include, but is not limited to, requests for other insurance information, accident reports and verification of dependent status.

By accepting Benefits under this plan, participants authorize and direct any person or institution that has provided services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the enrollment form. The Plan agrees that such information and records will be considered confidential.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for Clean Claims. While every Claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

CLAIMS NEGOTIATION

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accordance with the terms of this Plan Document.

The Plan reserves the right to reduce the cost of any out of network Claim to the Medicare reimbursement rate.

Schedule of Benefits

DEDUCTIBLE	
Individual Annual Deductible	$100
Family Annual Deductible	$200
MAXIMUMS	
Annual Maximum	$3,500 Per Person
Orthodontics Lifetime Maximum	$3,500 Per Person
PREVENTIVE & DIAGNOSTIC CARE	**Coverage**
Dental Exams – Limit 2 Per 12 months	No Charge
Cleanings including Periodontal Maintenance – Limit 2 Per 12 months	No Charge
Fluoride Treatments – Up to Age 19, Limit 2 per 12-month period	No Charge
Bitewing X-rays – one per 12-month period	No Charge
Occlusal X-rays – Limit 2 Per 24 months	No Charge
Panoramic X-Rays – Limit 1 per 36 consecutive months	No Charge
Space Maintainers – Up to age 15-Limit 1 per 60 consecutive months	No Charge
Sealants – Once per lifetime to age 15, 1st and 2nd molars, limited to one per tooth in any 12-month period.	No Charge
BASIC CARE	
Amalgam & Composite Fillings	20% Coinsurance After Deductible
Anesthesia	20% Coinsurance After Deductible
Emergency Palliative Treatment	20% Coinsurance After Deductible
Surgical Extractions	20% Coinsurance After Deductible
Pathology	20% Coinsurance After Deductible
Periodontics	20% Coinsurance After Deductible
Endodontics	20% Coinsurance After Deductible
Oral Surgery	20% Coinsurance After Deductible
MAJOR CARE	
Crowns, Gold Fillings, Inlays, Onlays, Implants, Pontics, Bridges, & Dentures.	50% Coinsurance After Deductible
Prosthetics	50% Coinsurance After Deductible
Orthodontics (No age restrictions)	50% Coinsurance After Deductible

Covered Dental Services

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

A) PREVENTIVE & DIAGNOSTIC SERVICES

1. Initial, Periodic or Diagnostic Oral Examinations. Limited to two (2) examinations each calendar year.

2. Prophylaxis and /or periodontal maintenance. Cleaning and scaling of teeth. Limited to two (2) cleanings in any calendar year.

3. Radiographs/X-Rays. Dental x-rays, intraoral or bitewings. Limited to one (1) series of full mouth x-rays including bitewings in any 36- month period and no more than two (2) series of supplementary bitewing x-rays in any calendar year.

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

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

6. Topical application of fluoride (excluding prophylaxis) for dependent children under the age of 19. Limited to two (2) treatments in any calendar year.

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

8. Occlusal night guards are limited to one in any 36-month period.

9. Sealants on the occlusal surface of a posterior permanent tooth for dependent children under the age of fifteen (15). Limited to one per tooth in any calendar year.

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

1. Consultations

2. Study models

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

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

5. Endodontic services including Root Canal Therapy.

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

7. Periodontic treatment or surgery to remove diseased gun tissue or bone. Limited to one scaling, curettage, or surgery per quadrant in any 6-month period.

8. Periodontic prophylaxis. Limited to one per quarter and in lieu of any other preventive prophylaxis treatment.

9. Occlusal adjustments, only in conjunction with periodontal surgery.

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

11. Nitrous oxide, for dependents under age twelve (12).

C) ***MAJOR SERVICES*** including Major Restorations, Dentures, Bridgework, Implants, and Prosthodontic Repairs.

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

2. Relining and Rebasing for full or partial dentures.

3. Crowns, inlays and onlays and gold restorations.

4. Periodontal appliances to stabilize periodontally involved teeth.

5. Veneers, unless cosmetic.

6. Installation of precision attachments for removable dentures.

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

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

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

10. The addition of teeth to an existing partial removable denture or existing fixed bridgework. Benefits are available only when the addition is to replace one (1) or more natural teeth extracted while you are covered under this Plan.

11. Dental Implants. Replacement of implants will be provided only after a five-year period measured from the date on which the existing implant was last supplied, regardless of whether the Cover Person was covered when the implant was supplied.

D) ***ORTHODONTIC SERVICES*** (No age restrictions).

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

12. Cephalometric x-rays;

13. Diagnostic casts for orthodontic purposed;

14. Surgical exposure of an impacted tooth for orthodontic purposes:

15. Orthodontic appliances for tooth guidance;

16. Fixed or removable appliances to correct harmful habits.

Definitions

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

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

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

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

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

Covered Person means an Employee or Dependent who is covered under this Plan.

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

Dental Service(s) means any service or class of services or supply provided to a Covered Individual for the dental diagnosis, treatment or care to the extent described under this Plan.

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

Employee shall mean a person who is employed by the Employer on a full-time basis and regularly scheduled to work at least thirty (30) hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least thirty (30) hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

The following definitions are associated with the Code Section 4980H (Employer Shared Responsibility) as enacted under the Affordable Care Act:

Administrative Period shall mean a period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time is used by the Employer to determine if Variable Hour Employees and/or Ongoing Employees are eligible for coverage and, if so, to make an offer of coverage. An Administrative Period may not exceed 90 days. The Employer may choose not to use an Administrative Period.

Full-time Employee or Full-Time Employment shall mean with respect to a calendar month, an Employee who is employed an average of at least 30 hours of service per week with the Employer.

Hour of Service shall mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an Employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

Measurement Period shall mean a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

Initial Measurement Period: For a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after a period of 3 to 12 consecutive months of service. The Employer determines the Initial Measurement Period and provides that information through its own internal procedures and documents, such the Employee Handbook.

Standard Measurement Period: For Ongoing Employees, this Measurement Period will start at a time designated by the Employer and will last for a period of 3 to 12 consecutive months of service. The Employer determines the Standard Measurement Period and provides that information through its own internal procedures and documents, such the Employee Handbook.

New Employee shall mean an Employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the Employee was credited with zero hours of service.

Non-variable Hour Employee shall mean an Employee reasonably expected at the time of hire to work 30 or more hours per week.

Ongoing Employee shall mean an Employee who has been employed by the Employer for at least one complete Measurement Period.

Seasonal Employee shall mean an Employee who is hired into a position for which the customary annual employment is six months or less.

Stability Period shall mean a period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period and, if elected by the Employer, the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period. The Stability Period is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's and/or Ongoing Employee's eligibility status is fixed.

Variable Hour Employee shall mean an Employee, based on the facts and circumstances at the Employee's start date, whose reasonable expectation of average hours per week cannot be determined.

Employer is Beus O'Connor McGroder, PLLC and its affiliated companies.

Endodontics means the treatment of diseases of the dental pulp, including root canal therapy.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

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

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

(1) a drug, device, dental treatment or procedure is experimental or investigational if the drug or device, medical treatment or procedure cannot be lawfully marketed or performed without approval of the U.S. Food and Drug Administration and approval for marketing or performance has not been given at the time the drug, device, medical treatment or procedure is provided;

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

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

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

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

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

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

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

Incurred means the date upon which services and supplies are rendered to you. Such services and supplied shall be considered to have been Incurred at the time or date the service or supply was actually purchased or provided.

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

Late Enrollee means a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time a Covered Person is covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

No Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Oral Surgery means the extraction and alveolectomy when performed as an independent procedure. Oral Surgery may include other oral treatment and surgery, if a Dentist considers it Medically Necessary. Oral Surgery does not include orthodontia, Orthognathic Surgery, placement of dental implants or surgical care that is necessary because of a medical condition.

Orthognathic Surgery means dental care or surgery for the correction of malpositioned jaw bones.

Periodontics means the treatment of diseases of the gingiva (gums) and bones support the teeth.

Plan means Beus O'Connor McGroder, PLLC which is a benefits plan for certain employees of Beus O'Connor McGroder, PLLC , and is described in this document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

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

Prior Plan means the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the effective date of the Plan and replaced by the Plan.

Prosthetic or Prosthesis means services or supplies to replace missing teeth, including construction, repair, replacement and fitting of bridgework and full or partial dentures.

Restorative Services means care required due to dental disease or tooth fracture.

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

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

Usual and Customary means a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

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

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

Waiting Period is the time between your date of hire and the date that you are eligible for medical benefits under the Plan.

Plan Exclusions

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

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

(2) **Athletic mouth guards.**

(3) **Bite registrations**

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

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

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

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

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

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

(10) **Government coverage.** Expenses for services and supplies, which are provided by any governmental agency, for which the Covered Person is not liable for payment, will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered person eligible under Tricare (the government sponsored program for military dependents).

(11) Expenses for treatment at a facility owned and operated by the **government** will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

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

(13) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(14) Charges for functional/myofunctional therapy and mouth guards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How to Submit a Claim

For the purposes of this section “claimant” shall mean any Covered Person or his or her authorized representative submitting a Claim to the Plan and thereby seeking to receive Plan benefits.

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

Typically, Providers will submit Claims directly to the Claims Administrator. However, when a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office or the Plan Administrator;

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED;

(3) Have the Physician complete the provider's portion of the form;

(4) For Plan reimbursements, attach bills for services rendered, ALL BILLS MUST SHOW:

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

(5) Send the above to the Claims Administrator at this address:

HealthEZ
P.O. Box 211186
Eagan, Minnesota 55121

WHEN CLAIMS SHOULD BE FILED

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

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

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

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan Processes Claims for benefits. The timetables listed below are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are three different categories of Claims: urgent care Claims, pre-service Claims, and post-service Claims.
Each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Pre-Service Claim

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

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

Post-Service Claim

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

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

Notice to Claimant of Adverse Benefit Determinations

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an

explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

(5) 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 Claim.

(6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

(7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, 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 free of charge, upon request.

Appeals

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

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

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

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take 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 initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

Coordination of Benefits

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

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

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

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

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

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

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

Right to receive or release necessary information. To make this provision work in accordance with HIPAA regulations, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

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

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

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

Third Party Recovery Provision

RIGHT OF SUBROGATION AND REFUND

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

The Covered Person:

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

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

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

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

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

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

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

1. To subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds ("Coverage") for which the Plan Beneficiary claims an entitlement to benefits under this plan, regardless of how classified or characterized and to reimburse the plan for any such benefits paid when recovery is made.

2. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Plan Beneficiary for the Injury or condition without obtaining the Plan's written approval; and in the event a Plan Beneficiary settles, recovers or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Plan Beneficiary acknowledges that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Plan Beneficiary as the result of the illness or Injury, regardless of whether the Plan Beneficiary is made whole. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any recovery or reimbursement received, the Plan Beneficiary will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recovery such money from the Plan Beneficiary. If the Plan Beneficiary decides to pursue a third party or any Coverage available to he/she as a result of the said Injury or condition, the Plan Beneficiary agrees to include the Plan's Subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Plan Beneficiary decides not to pursue any third parties or Coverage the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the plan in the prosecution of any such claims. The Plan Beneficiary shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or Injury. The Plan Beneficiary agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan. The plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. If the Injury or condition giving rise to subrogation involves a minor child or wrongful death of a Plan Beneficiary, this provision applies to the parents or guardian of the minor Plan Beneficiary and the personal representative of the deceased Plan Beneficiary. The Plan's remedies shall be equitable in nature and recovery may be made through the imposition of a constructive trust on a Plan Beneficiary's recovery.

Defined terms:

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

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

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

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

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

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

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

Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Beus O'Connor McGroder, PLLC Medical Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

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

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

The term "covered Employee" includes not only common-law employees (whether part-time, ¾ time, or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

(1) The death of a covered Employee;

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

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation;

(4) A covered Employee's enrollment in any part of the Medicare program; or,

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. If you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment;

(2) death of the employee;

(3) commencement of a proceeding in bankruptcy with respect to the employer; or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator (i.e. Employer).

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

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

(1) The last day of the applicable maximum coverage period;

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

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee;

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

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

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

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

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

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

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

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

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

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

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

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

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

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.

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

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

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

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

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

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

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

Responsibilities for Plan Administration

PLAN ADMINISTRATOR. Beus O'Connor McGroder, PLLC Medical Plan is the benefit plan of Beus O'Connor McGroder, PLLC , and its affiliates, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Beus O'Connor McGroder, PLLC to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Beus O'Connor McGroder, PLLC shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. 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 determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person'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.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Covered Person's rights.

(4) To prescribe procedures for filing a Claim for benefits and to review Claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay Claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS. Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

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

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

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

SUMMARY OF MATERIAL REDUCTION (SMR). A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than 60 days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The 60-day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next 90 days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

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 Employees 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.

Note: The Patient Protection and Affordable Care Act (PPACA) requires that if a Plan’s Material Modifications are not reflected in the Plan’s most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least 60 days before the effective date of the Material Modification.

Certain Covered Persons Rights under ERISA

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

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
>
> Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Continue health care coverage for a Covered Person, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.
>
> Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Covered Person's Claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a Claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, he or she should contact the Plan Administrator. If the Covered Person has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.).

Important Notices

COMPLIANCE WITH HIPAA PRIVACY AND PORTABILITY REQUIREMENTS

The Plan intends to comply with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA), including special enrollment rights and privacy rights and responsibilities. The Plan provides each Plan 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 contacting the HIPAA Compliance Officer listed in the section entitled General Plan Information and Establishment of the Plan.**

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSCOs)

The Plan has written procedures to determine whether a medical child support order qualifies for coverage under the plan by meeting certain requirements. The Plan will provide coverage pursuant to a medical child support order that does not qualify. Please contact 844-449-5545 to request of a copy of the written procedures used by the Plan Administrator to determine QMCSCOs.

General Plan Information & Establishment of the Plan

Name of Plan:	**Beus O'Connor McGroder, PLLC Dental Plan**
Plan Sponsor:	**Beus O'Connor McGroder, PLLC 701 N. 44th Street Phoenix, Arizona 85008**
Plan Administrator: (Named Fiduciary)	**Beus O'Connor McGroder, PLLC 701 N. 44th Street Phoenix, Arizona 85008**
Plan Sponsor ID No. (EIN):	**86-0901734**
Source of Funding:	**Self-Funded**
Applicable Law:	**ERISA**
Plan Year:	**January 1st to December 31st**
Plan Number:	**501**
Plan Type:	**Dental**
Claims Administrator:	**America's TPA dba HealthEZ PO Box 211186 Eagan, Minnesota 55121**
HIPAA Officer(s):	**Karen Mealha Ph: 480-429-3000**

Adoption of the Plan Document
Adoption of the Plan Document The Plan Sponsor, as the settlor of the Plan, hereby adopts this grandfathered 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.

BEUS O'CONNOR MCGRODER, PLLC

By: Karen Mealha

Name: Karen Mealha

Date: 5/3/2024

Karen Mealha