Georgia Dental Association
Health and Welfare Plan

(an ERISA wrap plan)

Restated for the plan year beginning January 1, 2016

Plan Sponsor:
Georgia Dental Association
7000 Peachtree Dunwoody Road
Bldg. 17, Suite 200
Atlanta, GA 30328
Contact: (404) 636-7553

Plan Number: 501

CONTENTS

HEALTH AND WELFARE PLAN
INTRODUCTION

Georgia Dental Association (the **"Association"),** acting as a bona fide association of employers, hereby adopts the Georgia Dental Association Health and Welfare Plan (the "Plan") effective as of January 1, 2013, for the benefit of its employer-members who may offer the Benefit Options under the Plan to their employees. The Plan is a multiple employer welfare arrangement **("MEWA")** subject to ERISA and regulation under state law.

The Plan is a group health plan established to combine various health and welfare benefits offered by the Association in a single document. This booklet and its attachments constitute the plan document and the summary plan description **("SPD")** for the Plan and for each of the Benefit Options as required by Section 102 of the Employee Retirement Income Security Act of 1974 **("ERISA").** The Association intends, for purposes of the annual report requirement (Form 5500) and for compliance with other laws, that this Plan be considered a "wrap" plan. The terms of the documents (including insurance contracts) that provide the terms and conditions of participation under each Benefit Option (referred to as the **"Summaries")** are incorporated by reference. The inclusion of any voluntary insurance coverages in this Plan is intended solely for consolidation purposes and is not intended to indicate that any such coverage is or is not subject to ERISA.

When used in this booklet (unless otherwise noted), the terms **"you"** and **"your"** mean a person who satisfies the eligibility requirements for the Plan and one or more Benefit Options.

From time to time there may be changes in the benefits and/or procedures under one or more of the Benefit Options contained in this Plan. In the case of a material change, the Association or Plan Administrator will notify you in writing of the change. Announcements will also be provided to you as required by law. Notices and announcements will normally be sent directly to the employee or eligible service provider (for himself or herself and covered family members) at the address that appears in your employer's records. For this reason, it is important that you notify your employer when you have a change of address. You should also keep announcements and notices with this booklet.

GENERAL INFORMATION ABOUT OUR PLAN

This Section contains certain general information that you may need to know about the Plan.

General:

Plan Name:	Georgia Dental Association Health and Welfare Plan
Plan Number:	501
Effective Date:	January 1, 2013
Plan Year:	January 1 to December 31

Plan Administrator:

Georgia Dental Insurance Services, Inc.
7000 Peachtree Dunwoody Road, Bldg. 17, Suite 200
Atlanta, GA 30328
Attn: Frank Capaldo
(404) 636-7553

EIN: 58-026250

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about our Plan. You may contact the Plan Administrator for any further information about the Plan.

Trustees

Mr. Keith Clark, Esq.
3425 Simpson Ferry Rd
Camp Hill, PA 17011

Dr. David Brown (dentist)
1010 Woodlands Rd
Watkinsville, GA 30677

Service of Legal Process

The Plan's agent for service of legal process is the Plan Administrator at the address listed above.

Type of Administration

The Benefit Options under the Plan are administered by the applicable insurer.

Named Fiduciary (for Benefit Claims)

The Plan Administrator is hereby designated as a "named fiduciary", within the meaning of ERISA Section 402(a), with respect to the operation and administration of the Plan and is responsible, except to the extent provided below, for administering the Plan in accordance with its terms. In addition, the insurance company is a "named fiduciary" with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

ERISA Coverage.

If a Benefit Option is not subject to ERISA, it is described as part of the Plan for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document.

Important Disclaimer

Benefits under this Plan are provided pursuant to an insurance contract and governing written plan document adopted by the Association. If the terms of this wrap document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this wrap document, unless otherwise required by law.

ARTICLE 1
YOUR ELIGIBILITY & PARTICIPATION

1.1 **Eligibility.** Employers who are members of the Association may offer the Benefit Options to their employees and other service providers. However, the right of each employee or service provider to enroll himself or herself and his or her eligible family members in each Benefit Option offered under this Plan is governed by the terms of each Benefit Option's Summary. Eligibility requirements are normally not the same for all Benefit Options, so be sure to review the applicable Summary.

In general, if you are eligible for a Benefit Option, you must complete an application form (available through your employer) to enroll yourself and/or your eligible family members. You must generally enroll within certain time periods after beginning work for your employer, as described in the Summary for each Benefit Option. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the start of each plan year.

1.2 **Special Enrollment Rights.** In certain circumstances and with respect to particular Benefit Options, enrollment may occur at times outside the open enrollment period (this is referred to as 'special enrollment"), as explained in the Summary for the applicable Benefit Option and your employer's cafeteria plan (sometimes called a "Section 125" plan), if any.

If you are declining enrollment for yourself or a spouse, children or dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and a spouse, children or dependents during the Plan Year in one or more Benefit Options under the Plan if you or your spouse, children or dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your spouse, children or dependents' other coverage). However, you must request enrollment within 31 days after your, or the spouse, children or dependents', other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new spouse, child or dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your spouse, child or dependents during the Plan Year in one or more Benefit Options under this Plan. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Also, if you are eligible for but not enrolled in the Plan, you may be able to enroll yourself and your spouse, children or dependents mid-Plan Year if you or your spouse, children or dependents lose eligibility for coverage under a State Medicaid or Children's Health Insurance Program Reauthorization Act **("CHIP")** or become eligible for premium assistance under Medicaid or CHIP (as described later in this Section). You must request enrollment within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined eligible for premium assistance.

1.3 Qualified Medical Child Support Orders. If the Plan receives an order from a court or administrative agency directing the Plan to cover your child under one or more Benefit Options offered under the Plan, the Plan will enroll your child in the Plan as provided in such order if the Plan Administrator determines the order is a Qualified Medical Child Support Order ("QMCSO") and your child would otherwise be an eligible dependent, as required by ERISA Section 609(a). Coverage may continue for the period specified in the QMCSO up to the time the child ceases to satisfy the definition of an eligible dependent under the applicable Benefit Option. If you are required to pay a higher premium to cover the child (e.g. for family coverage), your employer may increase your payroll deductions under its cafeteria plan. During the period the child is covered under the Plan as a result of a QMCSO, all Plan provisions and limits remain in effect with respect to the child's coverage, except as otherwise required by federal law.

The Plan has procedures for determining whether an order qualifies as a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the Association or the Plan Administrator.

1.4 **Cessation of Eligibility.** You will cease to participate in the Plan as of the earliest of (a) the date the employee/service provider is no longer eligible to participate in any of the Benefit Options, including but not limited to his or her failure to make a required contribution, (b) the date on which the employee/service provider withdraws, voluntarily or involuntarily, from all of the Benefit Options, (c) the date on which the Plan terminates, or (d) the date your employer no longer offers any Benefit Options to its employees or service providers through the Plan. If you are a covered family member, you will also cease to participate on an earlier date if you are no longer eligible to participate in or withdraw from the Plan. Cessation of eligibility for each Benefit Option may differ, and a specific Benefit Option may terminate independently of whether this Plan terminates. Consult the Summary for the particular Benefit Option for the rules governing cessation of eligibility.

1.5 **Leaves of Absence.** THE FEDERAL FAMILY AND MEDICAL LEAVE ACT OF 1993 AND THE REGULATIONS THEREUNDER **("FMLA")** APPLIES ONLY IF YOUR EMPLOYER HAS 50 OR MORE EMPLOYEES. If FMLA applies, this Plan will be operated in accordance with it. You may retain coverage for yourself and covered family members under one or more Benefit Options offered under this Plan during a leave taken under FMLA, provided that you continue to pay the applicable premiums in accordance with your employer's FMLA Policies. You should contact your employer's Human Resources department to determine whether it is subject to FMLA, whether a leave qualifies as FMLA leave, and the procedure for paying premiums during your leave.

One or more Benefit Options may also allow you to continue your coverage for up to 30 days during an employer-approved leave of absence, including sick leave, provided that you continue to pay the applicable premiums in accordance with your employer's leave policies. If the leave of absence also qualifies as FMLA leave, the 30-day leave time runs concurrently with the FMLA leave. Contact your employer's Human Resources department to determine whether such leaves of absence are offered and the procedure for paying premiums during leave.

1.6 **Medicaid And Children's Health Insurance Program (Chip) Offer Free Or Low-Cost Health Coverage To Children And Families.** If you are eligible for group health coverage Benefit Options under the Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your spouse, children or dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your spouse, children or dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your spouse, children or dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **vvww.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the Plan's health coverage.

Once it is determined that you or your spouse, children or dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the group health plan Benefit Options under the Plan — as long as you and your dependents are eligible, but not already enrolled in such Benefit Options under the Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2012. You should contact your state for further information on eligibility —

ALABAMA — Medicaid	**GEORGIA** — Medicaid
Website: www.medicaid.alabama.gov Phone: 1-855-692-5447	Website: dch.georgia.gov Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
NORTH CAROLINA — Medicaid	**FLORIDA** — Medicaid
Website: www.nedhhs.covidma Phone: 919-855-4100	Website: www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
SOUTH CAROLINA — Medicaid	
Website: www.scdhhs.gov Phone: 1-888-549-0820	

To see if any more states have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

1.7 **USERRA.** If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, benefits and service credit with respect to qualified military service will be provided in accordance with the Uniform Services Employment And Reemployment Rights Act and the regulations thereunder ("USERRA"). You should contact your employer's Human Resources department for more information about rights to continue coverage under this Plan.

ARTICLE 2
BENEFIT OPTIONS

2.1 **Benefit Options.** This Plan provides benefits through employee welfare benefit plans (as defined in ERISA Section 3(1)) sponsored by the Association and approved by the Plan Administrator for inclusion under this Plan (each is referred to as a **"Benefit Option").** These Benefit Options are provided through contracts with third-party insurers or vendors.

A current list of all Benefit Options under the Plan is attached as **Appendix A.**

Some of these Benefit Options require completion of application forms, annual elections, and/or other administrative forms. The details of these administrative requirements, and the terms of the Benefit Options, are described in the Summary for the applicable Benefit Option.

2.2 **Health Care Reform Notices.** Following is a list of some of the changes to the Plan that were made to comply with the Patient Protection and Affordable Care Act, as amended (known as **"Health Care Reform"** or **"PPACA"):**

(a) Adult Children Are Covered Until Age 26. You can cover your adult children (regardless of financial dependency, student status or residence) under the medical coverage offered through this Plan until they reach age 26 (please see the applicable certificate of coverage) to determine whether coverage ends on the child's 26th birthday or at the end of the month or calendar year in which the child reaches age 26, and whether any special rules apply as to the child's eligibility for another employer-sponsored plan). Your adult children whose medical coverage was previously denied or terminated

because they exceeded the age limits of our Plan or did not meet its residency, financial dependence or student status requirements, but are now eligible, were allowed at least 30 days in which to elect to enroll (this was explained in more detail in open enrollment materials sent to you prior to the start of the first plan year after this new rule took effect).

(b) No Exclusion of Pre-Existing Conditions. Pre-existing conditions are not excluded from medical coverage provided by Benefit Options offered under the Plan.

(c) No Lifetime or Annual Dollar Limits. No lifetime or annual limits apply to any essential health benefits provided by Benefit Options offered under the Plan.

(d) Primary Care Provider Designations. To the extent that any Benefit Option that provides medical coverage requires or allows for the designation of primary care providers by participants or beneficiaries, you have the right to designate any primary care provider who participates in-network and who is available to accept you or your family members; and to the extent that any Benefit Option that provides medical coverage requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider for the child.

(e) OB/GYN Designations. To the extent that any Benefit Option that provides medical coverage provides coverage for obstetric or gynecological care and requires the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from the Plan's network provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

(f) No Co-Pay for Preventive Services and Wellness Care. You are not required to pay a co-payment or other cost-sharing under the medical coverage offered through this Plan for preventive services and wellness benefits (as defined in the law), which include certain routine exams, immunizations, mammograms, and routine baby care. Please see the schedule of benefits in the applicable Benefit Option for more information.

(g) Emergency Services. You may seek emergency medical services at an in-network or out-of-network provider under Benefit Options providing medical coverage under this Plan without having to obtain prior authorization. Any out-of-network emergency medical services are subject to the same co-payments and deductibles as in-network emergency services, and the out-of-network provider will be paid at the same level as an in-network provider for the same service. Note, however, that the out-of-network provider may balance bill you for the difference between its charge for the emergency services and the amount paid by this Plan. Please see the applicable Benefit Option for more information.

2.3 **Newborns' and Mothers' Health Protection Act of 1996.** Benefit Options that provide medical coverage under this Plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean Section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

2.4 **Women's Health and Cancer Rights Act of 1998.** If your medical coverage under any of the Benefit Options includes coverage for mastectomy-related services, then you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 **("WHCRA").** For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. To obtain information on the deductibles and coinsurance that apply, refer to the respective Summary for the Benefit Option that provides the coverage for mastectomies or contact the insurer of the Benefit Option. If you would like more information on WHCRA benefits, call the Plan Administrator at the number listed in the General Information Section above.

ARTICLE 3
FUNDING

3.1 **Funding Through General Assets.** The Plan will be funded through the purchase of insurance from third parties. Unless otherwise required by law, nothing herein shall be construed to require your employer, the Association or the Plan Administrator to maintain any fund or trust, or segregate any amount for the benefit of any person, and no person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Association, the Plan Administrator or your employer from which any payment under the Plan may be made.

3.2 **Employee Contributions.** Each employee or service provider must pay his/her share of the cost of Benefit Options covering the employee/service provider and his or her covered family members under this Plan, as determined by the Association and/or the Plan Administrator from time to time, and your employer will pay the remainder (if any) of the cost.

In order for employees to pay this cost through salary reductions on a pre-tax basis, they must satisfy the requirements of their employer's cafeteria plan, which is contained in a separate plan document. In some cases where the employee is not eligible for the employer's cafeteria plan, where persons covered under a Benefit Option selected by the employee do not qualify for pre-tax benefits under the internal Revenue Code, or where a non-employee service provider is offered coverage in a Benefit Option, the employer in its sole discretion may allow the employee/service provider to pay all or part of the cost on an after-tax basis outside of the employer's cafeteria plan (in some limited situations described in the cafeteria plan, after-tax payments may be made through the cafeteria plan).

The Association and/or the Plan Administrator may, from time to time, implement or adopt one or more wellness programs or disease management programs under this Plan that offer you the opportunity to qualify for discounts on the cost of Benefit Options or other financial incentives if you participate in the program or satisfy certain health standards. If you choose to participate, or stop or otherwise fail to qualify in such a program, any adjustments will be automatically applied to the cost of your Benefit Options and to your salary reductions.

3.3 **Employer Contributions.** Your employer will make its contributions in an amount that (in the discretion of the Association and/or Plan Administrator) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Plan Administrator will forward the employer and employee/service provider contributions to the insurer. Any designation of employer premium amounts in open enrollment or other communications is intended as an estimate, not a fixed dollar amount, of your employer's contributions.

ARTICLE 4
COBRA CONTINUATION COVERAGE RIGHTS

4.1 **Application of COBRA.** If coverage under any Benefit Option that provides medical or dental coverage for you or your eligible family members under this Plan ceases because of certain "qualifying events" (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of an eligible dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1996 **("COBRA").**

4.2 **Notice.** In the event that a Benefit Option is subject to COBRA, this notice is intended to inform you and your 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 in the event a Benefit Option is subject to COBRA and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage in the event a Benefit Option is subject to COBRA. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to participants in the applicable Benefit Option who become Qualified Beneficiaries under COBRA.

4.3 **COBRA Continuation Coverage.** COBRA continuation coverage is the temporary extension of group health plan coverage (e.g. medical or dental) under a Benefit Option that must be offered to certain participants 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 applicable Benefit Option (the "Qualifying Event"). The coverage must be identical to the 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).

4.4 **Qualified Beneficiaries.** In general, a Qualified Beneficiary can be:

- any individual who, on the day before a Qualifying Event, is covered under the Benefit Option by virtue of being on that day either a covered employee, the spouse of a covered employee, or an eligible child of a covered employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the applicable Benefit Option 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 coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- 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 Benefit Option 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 applicable Benefit Option 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 coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term **"covered employee"** includes any individual who is provided coverage under the Benefit Option due to his or her performance of services for an employer member of the Association who adopts this Plan. However, this provision does not establish eligibility of these individuals. Eligibility for coverage under each Benefit Option shall be determined in accordance with the particular Benefit Option's 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 for purposes of COBRA (although a domestic partner may be entitled to separate continuation rights under applicable state law).

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.

4.5 **Qualifying Events.** A Qualifying Event is any of the following events provided that the event would cause the individual to 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 the opportunity to elect COBRA continuation coverage:

- The death of a covered employee.

- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.

- 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 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.

- A covered employee's enrollment in any part of the Medicare program.

- A dependent's or child's ceasing to satisfy the Benefit Option's requirements for eligibility (for example, attainment of the maximum age for coverage).

  If the Qualifying Event causes the covered employee, or the covered spouse or an eligible child of the covered employee, to cease to be covered under the Benefit Option 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 an eligible child of the covered employee, for coverage under the Benefit Option 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 a 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.

4.6 **Factors To Be Considered.** You should take into account that to obtain COBRA continuation coverage you will be responsible for paying 102% of the premium amount. Other options for health coverage, including coverage under a spouse's plan or a Health Insurance Marketplace plan, may be less expensive. For more information on coverage through the Health Insurance Marketplace in your State, please visit www.healthcare.gov. Additionally,

you should compare your current provider networks, drug formularies, and plan service areas when making decisions on your health care coverage.

4.7 **Procedure for Obtaining COBRA Coverage.** The Plan conditions the availability of COBRA continuation coverage with respect to any Benefit Option upon the timely election of such coverage. An election is timely if it is made during the election period.

(a) The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Benefit Option. The election period must begin not 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.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered spouse or children have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he or she and/or his or her family members may qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

If you have questions about the Trade Act of 2002 provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.clov/tradeact.

4.8 **Responsibility 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. Your employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment,
- death of the employee; or
- 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 an eligible child's losing eligibility for coverage as an eligible 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 child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

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 at the address listed in the General Information section above.

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 **Benefit Options** under which you lost or are losing coverage,

- the name and address of the employee covered under the Benefit Option,
- 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.

4.9 **Effect of a Waiver.** 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.

4.10 **COBRA Where Other Coverage or Medicare Available.** 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.

4.11 **When COBRA Coverage May 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:

- The last day of the applicable maximum coverage period.

- The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

- The date upon which the Association and its affiliates cease to provide any group health plan (including a successor plan) to any employee.

- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

  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).

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

- 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 a Benefit Option 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.

4.12 **Maximum Coverage Periods.** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) 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.

(b) 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:

- 36 months after the date the covered employee becomes enrolled in the Medicare program; or

- 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.

(c) 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.

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

(e) If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- 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 Administrator or its designee in accordance with the procedures above.

(f) 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 11 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 must be sent to the Plan Administrator or its designee in accordance with the procedures above.

4.13 **Payment for COBRA Coverage.** For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to 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 Administrator will inform you of the cost. 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.

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

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 Association and the entity that provides Plan benefits on the Association's behalf, the Association 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.

4.14 **Availability of Conversion Health Plan at End of COBRA.** If a Qualified Beneficiary's COBRA continuation coverage under a Benefit Option ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly-situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

4.15 **If You Have Questions.** If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. 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.**

4.16 **Update Your Address.** 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, or its designee.

4.17 **State Laws.** Your state may also require that you be given the right to purchase continued medical or dental coverage under this Plan. For employees of many smaller employers who are too small to be subject to federal COBRA requirements, these state laws may provide the only continuation rights. If you have questions about your state law continuation rights, see the Summary for the particular Benefit Option.

ARTICLE 5
CLAIMS PROCEDURE

5.1 **Claims for Fully insured Benefits.** For purposes of determining the amount of, and entitlement to, benefits under Benefit Options that are insured, the respective insurer is the "named fiduciary" under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Benefit Option, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. See the Summary for each Benefit Option for more information.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to file suit

in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan). See the Summary for each Benefit Option for more information.

5.2 **No Waiver.** Failure to insist upon compliance with any provision of a claims procedure at any given time or times or under any given set or sets of circumstances does not operate to waive or modify such provisions, or in any matter whatsoever to render the procedures unenforceable, whether the circumstances are, or are not, the same.

ARTICLE 6
HIPAA PRIVACY & SECURITY

6.1 **HIPAA Generally.** The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 **("HIPAA"),** certain of the Benefit Options offered under Plans such as this one, or their insurers, are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section explains some of HIPAA's requirements. You may request a copy of this notice by contacting the Association or the Plan Administrator.

6.2 **For Fully-Insured.** Since all Benefit Options in this Plan that provide health benefits are fully-insured, the Plan will not create or receive protected health information other than summary health information and enrollment and disenrollment information. As a result, the Plan is exempt from some of the notice and other administrative requirements imposed by HIPAA. The applicable insurer of each Benefit Option that provides health benefits will provide you a HIPAA notice of privacy practices. You may request a copy of this notice by contacting the applicable insurer.

6.3 **Disclosures of Protected Health Information. .**

(a) The Plan will not disclose your protected health information except to the extent allowed by HIPAA, which may include disclosing summary health information to the Association. The Association must limit its use of that information. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.

(b) Certain restrictions apply to the Association's use and disclosure of your protected health information:

- If the Association discloses any of your protected health information to any of its agents or subcontractors, the Association will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.

- The Association will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit Plan of the Association.

(c) Certain restrictions apply to the Plan Administrator's use and disclosure of your protected health information:

- The Plan Administrator will promptly report to the Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.

- The Plan Administrator will allow you or the Plan to inspect and copy any protected health information about you that is in the Association's custody and control. The HIPAA

regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.

- The Plan Administrator will amend, or allow the Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.

- With respect to some types of disclosures, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years. You have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services, or its designee.

- The Plan Administrator will, if feasible, return or destroy all of your protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate when the Plan Administrator no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy your protected health information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

6.4 **Authorized Workforce Members.** The following classes of employees or other workforce covered persons under the control of the Plan Administrator may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- HIPAA Privacy and Security Officers

- Benefit Administrators

If any of the foregoing employees or workforce covered persons of the Plan Administrator use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce covered persons will be subject to disciplinary action and sanctions, which may include termination of employment. If the Plan Administrator becomes aware of any such violation, the Plan Administrator will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

6.5 **Security of Your Personal Health Information.** Regardless of whether the Plan is exempted from some of the privacy requirements as described above, the following restrictions will apply to the Plan Administrator's storage and transmission of your electronic protected health information that comes into the possession of the Plan Administrator or its agents or subcontractors in the course of administering the Plan:

(a) The Plan Administrator will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce covered persons of the Plan Administrator described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations.

(b) If the Plan Administrator discloses any of your electronic protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations.

(c) The Plan Administrator will report to the Plan any security incident of which it becomes aware in accordance with the HIPAA regulations.

6.6 **Use and Disclosure of your Personal Health Information.** As business associates of the Plan, the insurers and third-party administrators who insure or administer the various Benefit Options under the Plan have agreements with the Plan that allow them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the Plan, you agree that the insurer or third-party administrator for the applicable Benefit Option may obtain, use and release all records about you and your minor dependents that it needs to administer the Plan or to perform any function authorized or permitted by law. You further direct all persons to release to the insurer or third-party administrator for the Benefit Option in which you have enrolled, all records about you and your minor dependents that it needs in order to administer the Benefit Option under the Plan.

If you have any questions regarding your rights under HIPAA, you should contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

If a Benefit Option providing health benefits is not exempted under the above rules, the Plan Administrator will provide you a notice of privacy practices and will comply with all applicable privacy safeguards provided under HIPAA.

6.7 **HIPAA Security.** Regardless of whether the Plan is exempted from some of the privacy requirements as described above, the following restrictions will apply to the Plan Administrator's storage and transmission of your electronic protected health information that comes into the possession of the Plan Administrator or its agents or subcontractors in the course of administering the Plan:

- The Plan Administrator will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce covered persons of the Plan Administrator described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations,

- If the Plan Administrator discloses any of your electronic protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to have in place the appropriate safeguards as required by the HIPAA regulations, and

- The Plan Administrator will report any security incident of which it becomes aware in accordance with the HIPAA regulations.

6.8 **Use and Disclosure of your Personal Health Information.** As business associates of the Plan, the insurers and third-party administrators who service the Benefit Options that provide group health benefits have agreements with the Plan that allow them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the Plan, you agree that such insurers and administrators may obtain, use and release all records about you and your minor family members that is needed to administer the Plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to such insurers and administrators about you and your minor children or other family members that it needs in order to administer Benefit Options or deliver benefits under the Plan.

If you have any questions regarding your rights under HIPAA, you should contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

ARTICLE 7
YOUR RIGHTS UNDER ERISA

7.1 Plan participants, eligible employees and all other employees of the Association may be entitled to certain rights and protections under ERISA and the Code. These laws provide that participants, eligible employees and all other employees are entitled to:

(a) **Receive Information About Your Plan and Benefits.**

- Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements (if any), and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration; and

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies;

(b) **COBRA and HIPAA Rights.**

- Continue health coverage for a participant or covered dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants or covered dependents may have to pay for such coverage. Review this booklet and the Summary for each Benefit Option for the rules governing COBRA continuation rights;

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, if you are over age 19 you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage (this preexisting condition exclusion will no longer apply effective January 1, 2014); and

7.2 **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your employer, the Association or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

7.3 **Enforcement.** Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

7.4 **Assistance with Your Questions.** If you have any questions about the Plan, you should contact the Plan Administrator's Human Resources department at the address and phone listed in the General Information Section at the beginning of this booklet. If you have any questions about this statement, or about your rights under ERISA or HIPAA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE 8
ADMINISTRATION

8.1 **The Plan Administrator.** The Plan is currently administered by the Georgia Dental Insurance Services, Inc., as the Plan Administrator. Any director of the Board of Directors of the Georgia Dental Insurance Services, Inc. who is not an employer within the meaning of Section 3(5) of the Employee Retirement Income Security Act of 1974 ("ERISA") does not participate in the decisions regarding or governance of any insured product offered through this Plan or any administrative matters related thereto. The Plan Administrator may adopt such rules as it deems desirable for the administration of the Plan or any of the Benefit Options. The Plan Administrator may engage one or more third parties to assist in the administration of the Plan and the Benefit Options, and may delegate any of its duties or powers to a third party.

8.2 **Powers of the Plan Administrator.** The Plan Administrator has full discretionary authority to administer and interpret the Plan, including discretionary authority to interpret its terms, make determinations of fact, and determine eligibility for participation and benefits under the Plan and any Benefit Option. The Plan Administrator may, however, delegate its discretionary authority and such duties and responsibilities as the Plan Administrator deems appropriate to facilitate the day-to-day administration of the Plan or any Benefit Option. Any determination of the Plan Administrator or its delegate is binding, final and conclusive upon all persons. In carrying out its duties with respect to the general administration of the Plan, the Plan Administrator has, in addition to the foregoing powers and any other powers conferred by this Plan, the Summary, or by law, the following powers:

(a) to construe the terms of the Plan and the Benefit Options and to determine all questions arising in its administration, interpretation, application or operation;

(b) to decide all questions relating to the eligibility of individuals to participate in the benefits provided under the Plan or its Benefit Options;

(c) to determine the benefits under the Plan or its Benefit Options to which any person may

be entitled;

(d) to keep records of all acts and determinations of the Plan Administrator and to keep all such records, books, accounts, data and other documents as may be necessary for the proper administration of the Plan;

(e) to make and publish such rules for the administration of the Plan as are not inconsistent with its terms;

(f) to prepare and distribute to all participants and covered family members information concerning the Plan, the Benefit Options, and the rights of the participants and covered family members under the Plan, including, but not limited to, all information which is required to be distributed under the Internal Revenue Code, ERISA, or their regulations;

(g) to file with the Secretary of Labor or the Secretary of the Treasury any and all reports or information required to be filed under the Internal Revenue Code or ERISA, and their regulations;

(h) to employ counsel, accountants and other consultants to aid in exercising its powers and carrying out its duties under the Plan; and

(I) to perform any other acts necessary and proper for the administration of the Plan.

8.3 **Insurance Control Clause.** Certain Benefit Options offered under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between the Plan and the insurance company. Claims for benefits are sent to the insurance company. The insurance company is responsible for determining and paying claims, not the Plan Administrator. As the "named fiduciary" for benefit determinations under fully-insured Benefit Options, the insurance company has the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance company also has the authority to require eligible persons to furnish it with such information as the insurance company determines necessary for the proper administration of the Plan. In the event of a conflict between the terms of this Plan and the terms of the insurance contract, the terms of the insurance contract shall control as to those persons receiving coverage under such Benefit Option. For this purpose, the insurance contract shall control in defining the persons eligible for the Benefit Option, the dates of their eligibility, the conditions which must be satisfied to become insured or otherwise participate in the Benefit Option, if any, the benefits that all persons covered by that Benefit Option are entitled to, and the circumstances under which the eligibility for the Benefit Option, and the underlying insurance, terminates.

8.4 **Delegation.** The Plan Administrator may establish procedures for the designation of persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the Plan. If any fiduciary responsibility is allocated or delegated to any person, no named fiduciary is liable for any act or omission of such person, except as provided in ERISA Section 405(c).

8.5 **Expenses of the Plan Administrator.** The Plan does not pay compensation to the Plan Administrator. The Plan may reimburse the Plan Administrator for its direct expenses incurred in performing its duties on behalf of the Plan. Accordingly, a percentage of Employee or Employer Contributions or income thereon may be used to cover such expenses. Expenses reimbursable to the Plan Administrator include, but are not limited to, fees of legal counsel, accountants and other specialists, plan communication and recordkeeping costs, plan audit fees, claims review, and vendor searches.

8.6 **Subscription Fee.** The Plan Administrator charges a subscription fee directly to Employers in connection with their participation in the Plan. The fee is paid by the Employers out of their general assets and is receivable by the Plan Administrator to its general assets. The fee is not an Employer Contribution to the Plan.

8.7 **Electronic Forms.** To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

ARTICLE 9
MISCELLANEOUS

9.1 **Association Protective Clauses.** Upon the failure of any participant, person or the Association to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect, or otherwise), benefits shall be limited to the insurance premium(s), if any, that remain unpaid for the coverage under the Benefit Option for the period in question and the actual insurance proceeds, if any, received by the Association or you as a result of your claim. The Association shall not be responsible for the validity of any insurance contract issued under the Plan or for the failure on the part of the insurer to make payments provided for under any insurance contract. Once insurance is applied for or obtained, neither the Plan Administrator nor the Association shall be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Plan Administrator or Association.

9.2 **No Guarantee of Tax Consequences.** Neither the Plan Administrator nor the Association makes any commitment or guarantee that any amounts paid to or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Association if you have reason to believe that any such payment is not so excludable.

9.3 **Indemnification of Association by Participants.** If you receive one or more payments or reimbursements under the Plan that are not for a permitted benefit under the Plan, you must indemnify and reimburse the Association for any liability the Association may incur for failure to withhold Federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the participant.

9.4 **Association's Right to Distributions.** To the fullest extent permitted by ERISA and other applicable law, any distribution from an insurance issuer, such as an insurance company, to its policyholders shall be payable solely to the Association. Distributions for this purpose shall include, but not be limited to, refunds, dividends, demutualization payments, rebates and excess surplus distributions, but shall not include payments or reimbursement for a Participant's claims for benefits.

9.5 **Affiliates.** Unless the context requires otherwise (such as designations of the plan sponsor and Plan Administrator, and granting of powers to amend and terminate the Plan), references to the Association include any U.S. subsidiary or U.S. affiliate of the Association. **'Affiliate"** means any entity which is a member of a controlled group of corporations with the Association; under common control with the Association; or a member of an affiliated service group with the Association, as such terms are defined in Code Section 414.

9.6 **Governing Law.** The construction and operation of the Plan are governed by the laws of the United States and, to the extent that such laws do not apply, by those of the State of **Georgia.**

9.7 **Severability.** If any provision of this Plan is held illegal or invalid for any reason, the remaining provisions are to remain in full force and effect and to be construed and enforced in accordance with the purposes of the Plan as if the illegal or invalid provision did not exist.

9.8 **Undefined Terms.** Unless the context clearly requires another meaning, any term not specifically defined in this Plan shall be interpreted by the Plan Administrator, whose interpretation shall be final and binding on all participants.

9.9 **Headings.** The headings of articles, sections and subsections are for the convenience of reference only and are not to be regarded as part of the Plan nor utilized in construing the Plan.

9.10 **Singular and Plural.** Unless clearly inappropriate, singular terms refer also to the plural and vice versa.

9.11 **Plan Not a Contract of Employment.** The adoption and maintenance of the Plan does not constitute a contract of employment between your employer and you and is not a consideration for the employment of any person. Nothing herein contained gives you the right to be retained in the employ of your employer or derogates from the right of your employer to discharge or take other appropriate action against you at any time without regard to the effect of such discharge or action upon your rights under the Plan.

9.12 **No Third-Party Rights under Plan.** Nothing in this Plan, express or implied, is intended, or shall be construed, to confer upon or give to any person, firm, association, or corporation, other than the parties hereto and their successors in interest, any right, remedy, or claim under or by reason of this Plan or any covenant, condition, or stipulation hereof, and all covenants, conditions and stipulations in this Plan, by or on behalf of any party, are for the sole and exclusive benefit of the parties hereto.

9.13 **Nontransferability of Interests.** Except as otherwise required by law, your rights to benefits under this Plan are not subject to your debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

9.14 **Facility of Payment.** If at any time you are, in the judgment of the Plan Administrator, legally, physically or mentally incapable of receiving any distribution or benefits due to you, the distribution or benefit may, if the Plan Administrator so directs and the law allows, be made to your guardian or legal representative, or, if none exists, to any other person or institution that, in the Plan Administrator's judgment, will apply the distribution in your best interests.

9.15 **Prohibition on Rescissions.** The Benefit Options that are subject to PPACA as 'group health plans" will not rescind coverage with respect to any individual once the individual is covered under the Benefit Option, except where the individual has committed an act of fraud, intentional misrepresentation of material fact, or other permitted circumstances, all as described in PPACA. Where coverage is permitted to be cancelled, the Plan Administrator, or its delegate will provide prior notice of cancellation to the individual as required by PPACA.

9.16 **Amendment of the Plan.** The Association, as the sponsor of the Plan, has the general right to amend or terminate the Plan at any time. The Association may delegate this authority to the Plan Administrator. The Plan may be amended or terminated by a written instrument signed by the Association's President, who is authorized to amend or terminate the Plan and to sign insurance contracts with the insurance companies, including amendments to those contracts, or by resolution of the Board of Directors of Georgia Dental Insurance Services, Inc., as Plan Administrator. Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component program offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

Unless prohibited by law, amendments may take effect retroactively, including the provisions of the Summary to the degree not precluded thereby. No amendment requires the consent of any participant, any participant's spouse, family members or beneficiary, or any other person.

IN WITNESS WHEREOF, the Association has caused this Plan to be executed by its duly authorized officer.

Date: December 20, 2015

Georgia Dental Association

By: Tom Broderick

Name: Dr. Tom Broderick

Title: President

APPENDIX A

BENEFIT OPTIONS

The following Benefit Options are currently offered to Participants:

Type of Benefit Option	Funding
Medical	Insured
Life/AD&D	Insured

The terms and conditions of these Benefit Options are documented in the applicable Summaries, including the insurance contracts purchased to provide benefits. The Benefit Options are specifically approved by the Association or the Plan Administrator for inclusion under this Plan. The Summaries setting forth the terms and conditions of each Benefit Option are incorporated by reference into this Plan.

The Association or the Plan Administrator may add or remove Benefit Options provided as a component of this Plan at any time.