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This plan details include the following:

2022 Benefit Summary and Rates

Dental Plan

Deductible Applies to Class II & III Services	$50 per Individual / $150 per Family
Annual Maximum Benefit (based on Calendar Year)	$1,000
Class I – Preventive Services Dental exams, cleanings, fluoride treatments, x-rays	100% Deductible waived
Class II – Basic Services Fillings, oral surgery, tooth extractions	80% Deductible applies
Class III – Major Services* Prosthetics, crowns, inlays, onlays, bridges	50% Deductible applies
Class IV – Orthodontics Lifetime Maximum Benefit Age Limitation	50% $1,000 Dependent children through age 19

* 12 month wait applies to Class III services. Waiting period is waived for employees who have had 12 consecutive months of comparable coverage under a prior plan immediately prior to becoming effective on this plan.

Enrollment

The dental plan does NOT include an Open Enrollment provision. To receive coverage, an eligible employee and/or eligible family dependent must enroll within 31 days after becoming eligible. If you do not enroll yourself and/or your dependents when first eligible for coverage under this Plan, you may do so at any time, including at the annual enrollment period in December. Late or Deferred Coverage limitations may apply.

Deferred Coverage Limits: Benefits will be paid for Class I services only for the first 12 months.

Rates Effective (1/1/2022 – 12/31/2022)	Payroll Cycle (per paycheck)			
	Weekly	Bi-Weekly	Semi-Monthly	Monthly
Employee Only	$11.42	$22.85	$24.75	$49.50
Employee & Spouse/Domestic Partner	$22.41	$44.81	$48.55	$97.09
Employee & Family	$37.51	$75.02	$81.27	$162.54
Employee & Child(ren)	$26.37	$52.73	$57.13	$114.25

Note: Periodic deduction amounts may change when Cardinal has to do a retro-deduction due to missed payroll, or when coverage comes into effect after January 2022.

Eligibility Requirement & Waiting Period Information:

- New Hires – 1st of the month following 60 days from the date of hire with the Employer of Record
- Part time to Full time status: Waiting period - Starts from full time status
- Temporary & Seasonal Employees are not eligible
- If the last day of the waiting period falls on the first calendar day of a month, coverage begins on that day

Minimum hours: 30 hours per week

Returning to Work after a Layoff: If an Employee is laid off for 31 days or more and then rehired, the Employee will be considered a new hire and will have to re-satisfy all eligibility requirements. An enrollment form must be submitted to the Plan Administrator within 30 days of becoming eligible for coverage.

Cardinal Services, INC.
Employee Dental and Vision Benefit Plan
Amendment
Effective January 1st, 2022

As of the effective date of this amendment, the following will apply:

(2) Annual Enrollment Period:

There will be an Annual Enrollment period for one month each year beginning December 1st and ending December 31st, for eligible employees and their dependents. Late or deferred enrollment limitations may apply. Coverage will become effective on January 1st following the annual enrollment period.

IN WITNESS WHEREOF, the Company has executed, and the Plan Supervisor has acknowledged, the amendment to the Plan Document as of the Amendment Effective Date shown herein.

PLAN SPONSOR	PLAN ADMINISTRATOR
_____	_____
Cardinal Services, INC.	ARM, Ltd.
_____	_____
Date	Date

CARDINAL SERVICES, INC.

DENTAL PLAN

Plan Document and Summary Plan Description

As Amended and Restated Effective January 1, 2022

PLAN DOCUMENT ACCEPTANCE

BY THIS AGREEMENT, the Cardinal Services, Inc. Employee Dental Plan document as Amended and Restated effective January 1, 2022 is hereby accepted and adopted as stated herein.

IN WITNESS WHEREOF, the Company has executed, and the Plan Supervisor has acknowledged, the amendment to the Plan Document as of the Amendment Effective Date shown herein.

PLAN SPONSOR	PLAN ADMINISTRATOR
_____	_____
Cardinal Services, INC.	ARM, Ltd.
_____	_____
Date	Date

INTRODUCTION

This document is a description of the Cardinal Services, Inc. Employee Dental Plan. This Plan was established February 1, 2003 for the benefit of the eligible Employees and their eligible Dependents. The purpose of this Plan is to provide comprehensive dental care protection for eligible Employees and their Dependents.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the waiting period and all the eligibility requirements of the Plan.

Cardinal Services, Inc. fully intends to maintain this Plan indefinitely. However, future conditions cannot be foreseen and Cardinal Services, Inc. reserves the right to amend, modify, suspend, or terminate the Plan at any time and for any reasons.

The Plan will pay benefits only for the expenses incurred while coverage under the Plan is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminates. An expense for a service or supply is incurred on the date the service or supply is furnished.

The Plan Administrator shall have full power and authority to control and manage the operation and administration of the Plan and to construe and apply all of its provisions including the specific power and authority to interpret the Plan and to remedy and resolve ambiguities, inconsistencies or omissions.

Any questions regarding eligibility, claims status, or benefits should be directed to the Claims Administrator:

ARM, Ltd
814 W Northwest Hwy Ave
Arlington Hts IL
60004

Telephone Number: 847-394-1700
Toll Free: 800-392-1770

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SECTION 1
SCHEDULE OF DENTAL BENEFITS

Plan Limits:	$1,000 per Covered Person each Calendar Year
Annual Deductible:	$50 per Covered Person /$150 per Family Unit each Calendar Year

This plan does not utilize a network of preferred dental providers. You may use the services of the licensed dental provider of your choice.

COVERED DENTAL SERVICES	AMOUNT PLAN COVERS
• **Preventive Services** Cleaning, Exams & X-rays	100% UCR - Annual Deductible is waived
• **Basic Services** Extractions, Periodontal Services, Fillings, Root Canals & Oral Surgical Extractions	80% UCR
• **Major Services** * Crowns, Bridges & Dentures	50% UCR

* 12 months of continuous coverage is required before coverage is available for Major Dental services.

ORTHODONTIC SERVICES

Plan Limits:	$1,000 Lifetime Maximum Benefit (Orthodontic benefits are only available to Dependent children age 19 and under)
Annual Deductible:	None

COVERED SERVICES	AMOUNT PLAN COVERS
• **Treatment of handicapped malocclusion including banding, orthodontic appliances and orthodontic treatments**	50% UCR

Please refer to the ***Dental Plan Benefits Section*** of this document for a detailed listing of Covered Expenses and the ***Dental Plan Exclusions Section*** for limitations and exclusions of certain dental services and treatments.

SECTION 2
ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE

ELIGIBILITY

Only those employees of the Employer and the members of their families as defined in the definitions under "Eligible Employee" and "Eligible Dependents," shall be eligible for benefits under this Plan.

ENROLLMENT

Enrollment hereunder shall be made in writing on Enrollment Forms provided by the Employer. On the effective date of the Plan, all eligible employees and eligible dependents whose applications have been accepted by the Plan Administrator, will become participants under the Plan. Employees hired after the original effective date of this Plan must complete an enrollment form within 31 days of becoming eligible for coverage.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date of Coverage
An employee will be covered as of the first day of the calendar month following 60 days of continuous employment if the employee satisfies all of the following:

1. Meets the definition of an "Eligible Employee" (see ***Defined Terms Section*** of this document).

2. Completes the required enrollment form.

Dependent Effective Date of Coverage
Dependents will be covered simultaneously with the employee if the following conditions are met:

1. The required enrollment form has been completed.

2. The dependent(s) to be covered meet the definition of an eligible dependent.

ENROLLING NEWLY ACQUIRED DEPENDENTS

Newly acquired Dependents will become effective on the first day of the calendar month following the month they become eligible Dependents. A new enrollment form must be filed with the Plan Administrator. Claims submitted for a person not listed on the enrollment form will be denied.

Qualified Medical Child Support Order. A Qualified Medical Child Support Order (QMCSO) is a court judgment, decree, or order, or a state administrative order that has the force and effect of law, that is typically issued as part of a divorce or as part of a state child support order proceeding, and that requires health plan coverage for an "alternate recipient", the child of a participant. Federal law requires a group health plan to pay benefits in accordance with such an order, if it is "qualified". The Enrollment and Benefit provisions of this Plan will apply to the "alternate recipient" of a QMCSO the same as they do to any other eligible Dependent.

The effective date of coverage for a child added to this Plan due to a QMCSO is the date of the court order or the date that is specified in the court order.

Coverage Status Change. 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.

Any changes in coverage status do not interrupt participation in the Plan and do not change a Covered Person's effective date of coverage for purposes of the Preexisting Condition definitions.

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

If both husband and wife are covered under this Plan as Employees, their Dependent children may be covered as Dependents of the husband or wife, but not by both.

ENROLLING DURING THE INITIAL ENROLLMENT PERIOD

The "Initial Enrollment Period" is the 31-day period beginning on the date a person is first eligible for enrollment in this Plan. Each person who becomes eligible for coverage under this Plan has an initial enrollment period.

To enroll in this Plan the eligible Employee must complete and sign an enrollment application and submit the application to the Plan Administrator within the initial enrollment period. The enrollment form must include complete information on the Employee and any eligible Dependents who are to be enrolled in the Plan.

Enrollment of Newborn Children. A Plan Participant's newborn baby is automatically covered under this plan during the 31-day initial enrollment period after birth. To add the child to coverage under this Plan beyond that date, an enrollment application must be submitted listing the child as an eligible dependent.

1. If a premium is required, then the baby's eligibility for coverage will end 31 days after birth if the Plan Administrator has not received an enrollment application and the required premium to cover the baby.

2. If no additional premium is required, then the baby's eligibility continues as long as the Employee is covered.

3. The newborn child cannot be enrolled in this Plan, and benefits cannot be paid until the Plan Administrator receives the enrollment application listing the child as an eligible dependent. If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

Enrollment of Adopted Children. When a child is placed for adoption, the child is automatically covered under this Plan during the 31-day initial enrollment period after placement. "Placement" means the Plan Participant has assumed financial responsibility for the support and care of the child in anticipation of adoption. To add the child to coverage under this Plan beyond the first 31 days, an enrollment form must be submitted to the Plan Administrator listing the child as an eligible dependent.

1. If a premium is required, then the child's eligibility for coverage will end 31 days after placement if the Plan Administrator has not received an enrollment application and the required premium to cover the child.

2. If no additional premium is required, then the child's eligibility continues as long as the Employee is covered.

3. The child placed for adoption cannot be enrolled in this Plan, and benefits cannot be paid until the Plan Administrator receives the enrollment application listing the child as an eligible dependent. If the child is not enrolled within 31 days of placement for adoption, the enrollment will be considered a Late Enrollment.

Enrolling Family Members Acquired by Marriage. A Plan Participant who marries may add a new Spouse and any eligible dependent children to coverage under this Plan during the 31-day initial enrollment period after the date of the marriage. The Plan Administrator must receive an enrollment form and the additional premium required, if any, during the initial enrollment period. Coverage for the new family members will become effective on the first day of the month after the date of the marriage.

Court Ordered Coverage. If a Court orders coverage for a Spouse or a child, they may enroll in this Plan during the 31-day initial enrollment period. In this case, the initial enrollment period begins on the date of the court order. Coverage will become effective on the first day of the month after the Plan Administrator receives the enrollment form.

ENROLLING AFTER THE INITIAL ENROLLMENT PERIOD

Late or Deferred Enrollment. An enrollment is "late" or "deferred" if it is not made on a "timely basis". A "late enrollee" is an otherwise eligible Employee or Dependent who does not qualify for a Special Enrollment period (described below) and who:

1. Did not enroll during the 31-day initial enrollment period; or

2. Enrolled during the initial enrollment period but discontinued coverage later.

If **you request coverage for you or your dependents more than 31 days after the date the person is eligible, benefits will be limited as follows:**

- During the first 12 months benefits will only be payable for covered Preventive Services. No benefits will be payable during the first 12 months for any Basic or Major or Orthodontic services.

- After coverage has been in force for 12 consecutive months, benefits will be payable for covered charges under Preventive, Basic, Major, and Orthodontic.

Returning to Work after a Layoff. If an Employee is laid off for 31 days or more and then rehired, the Employee will be considered a new hire and will have to re-satisfy all eligibility requirements. An enrollment form must be submitted to the Plan Administrator within 30 days of becoming eligible for coverage.

Special Enrollment Periods. If an eligible Employee declines enrollment for himself or his Dependents (including his Spouse) because of other health insurance coverage, he may in the future be able to enroll himself or his Dependents in this plan, provided that he requests enrollment on or before 31 days after the other coverage ends. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, he may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within the specific period after the marriage, birth, adoption, or placement for adoption.

The enrollment date for anyone who enrolls under the Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

1. Individuals losing their 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(s) who has 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 toward the coverage were terminated.

    d) The Employee 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.

    e) If the Employee or Dependent lost the other coverage because of the individual's failure to pay premiums or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

2. Dependent beneficiaries. 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

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

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.

The coverage of the Dependents enrolled in the Special Enrollment Period will become effective:

1. In the case of a marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received by the Plan Administrator;

2. In the case of the Dependent's birth, as of the date of birth; or

3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

LEAVE OF ABSENCE

If you are granted a leave of absence under the Family and Medical Leave Act of 1993, the Employer will continue to provide coverage without condition during the leave and upon return from the leave, on the same basis as was provided during active employment.

SECTION 3
TERMINATION OF COVERAGE

Coverage under this Plan shall terminate on the earliest of the following dates:

1. The date of termination of the Plan;

2. The last day of the month in which the employee's employment terminates, except that in the event the Covered Employee is absent on account of Total Disability, Active Service will terminate for the purposes of this coverage on the date employer contributions for the Covered Employee's coverage are discontinued, administered pursuant to current company policy and in a manner which would preclude individual selection;

3. The last day of the month in which membership ceases in an eligible class;

4. The date the covered individual becomes a full-time member of the armed forces of any country; or

5. The first day of the month in which the covered person fails to make any required contribution.

Continuation of coverage during Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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 the 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 a new Dependent is acquired while the Employee is covered under the FMLA provisions, the Dependent will be eligible for coverage under this Plan on the same provisions as those stated for Active Employees.

Employees on Military Leave. 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 **(USERRA)** under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately 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 24-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 of employment and fails to do so.

2. A person who elects to continue health plan coverage must 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 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 an Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan is terminated.

2. The last day of the month in which the Employee's coverage under the Plan terminates for any reason including death.

3. On the last day of the month in which he or she ceases to be a Dependent as defined by the Plan.

4. 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.

A covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, please refer to the ***COBRA Continuation Coverage Section*** of this document.

LOSS OF ELIGIBILITY BY DEPENDENTS

Coverage ends for a spouse of an employee if the marriage is legally dissolved. It ends on the last day of the monthly period in which a decree of divorce or annulment is entered (not when the decree becomes final). Such spouse may be eligible for continuation coverage under COBRA.

Coverage ends for an enrolled child on the last day of the monthly period in which the child is no longer eligible because he or she no longer satisfies the definition of an "Eligible Dependent". Such children may be eligible for continuation coverage under COBRA.

LOSS OF EMPLOYEE'S ELIGIBILITY

If an employee is no longer eligible, his or her coverage and the coverage of all covered family members will be continued until the end of the current month for which the employee worked and required contributions were paid even though the employee may leave the employ of the Company prior to the end of that month.

EMPLOYEE OR FAMILY MEMBER COVERED IN ERROR

Any employee or family member who is covered in error under the Plan or who is covered in violation of any of the terms and conditions of the Plan shall not be entitled to any benefits hereunder. The Plan shall have the right to recover from any employee or member of his or her family the cost of any benefits furnished while such employee or family member was covered hereunder in error.

SECTION 4
DENTAL PLAN BENEFITS

Dental Benefits apply when covered charges are incurred by a Covered Person for and while the person is covered for these benefits under the Plan.

THIS PLAN DOES NOT UTILIZE A NETWORK OF PREFERRED DENTAL PROVIDERS. You may use the services of the licensed dental provider of your choice.

ANNUAL DEDUCTIBLE

The Annual Deductible is the amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the Annual Deductible as shown in the ***Schedule of Benefits Section*** (the Annual Deductible is waived for Preventive services). The Deductible needs to be satisfied only once per Calendar Year. The Deductible applies to covered expenses for each Calendar Year.

BENEFIT PAYMENT

This Plan will pay the percentage stated in the ***Schedule of Benefits Section*** except that the Covered Person must pay the amounts needed to satisfy any Deductible listed in the ***Schedule of Benefits Section.***

No benefits will be paid in excess of the Annual Plan limits as stated in the ***Schedule of Benefits Section.***

If you were covered on the initial effective date of this Plan and you transferred directly, with no lapse in coverage, to this Plan from the dental plan that was carried by the Employer immediately preceding this Plan, credit will be applied for amounts paid to satisfy any Deductible under the previous plan.

DENTAL CHARGES

Dental charges are the Usual Customary and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Contract/Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL EXPENSES

1. PREVENTIVE SERVICES - Reimbursed at 100% UCR - Deductible Waived
   a) Oral examination (Once every 6 months).

   b) Prophylaxis, including cleaning, scaling and polishing.

   c) Topical fluoride application.

   d) Dental X-Rays.

   e) Sealants for covered individuals age 19 and under, once every twelve (12) months.

2. BASIC SERVICES – Reimbursed at 80% UCR – subject to the Annual Deductible

   a) Palliative emergency treatment.

   b) Fillings.

   c) Extractions.

   d) Endodontics and root canal treatment.

   e) Space maintainers, but not their replacement.

   f) Diagnosis and treatment of cyst and abscess when directly related to the structure of a tooth.

   g) Non-Surgical Periodontal Services.

   h) Repair of dentures, bridges or crowns.

   i) Oral surgical extractions.

   j) Anesthesia when administered by a dentist in connection with a covered oral surgical procedure performed in a dental office.

3. MAJOR SERVICES - Reimbursed at 50% UCR -- subject to the Annual Deductible

   a) Inlays, onlays.

   b) Crowns.

   c) Bridges, fixed and removable.

   d) Dentures, full and partial.

   e) Surgical Periodontal Services.

Major Services Waiting Period: a twelve (12) month waiting period will be applied for Major Services for newly eligible participants that do not have immediate prior coverage. Proof of 12 months of continuous prior coverage will be required to waive the waiting period.

ORTHODONTIC SERVICES

f) Benefits for Orthodontic treatment will be provided for orthodontia services up the Lifetime Maximum Benefit shown in the ***Schedule of Benefits Section.***

g) Orthodontia Services are covered only for eligible dependent children age 19 and under.

h) Benefits will be provided for handicapped malocclusion consisting of the installations of orthodontic appliances and orthodontic treatments.

UCR - All benefits payable under this plan are subject to UCR. UCR means that the charge for advice, services, supplies and/or treatment must be the provider's regular charge and that it falls within the usual, customary and reasonable range of charges prevailing in that geographical area for like services as determined by the company retained to provide such information for this plan. Charges in excess of these allowances are excluded from coverage.

PREDETERMINATION OF BENEFITS

Before starting dental treatment, a predetermination of benefits form may be submitted to the Contract/Claims Administrator. The Dentist must itemize all recommended services and costs and send the form to the Contract/Claims Administrator.

The Contract/Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

SECTION 5
DENTAL PLAN EXCLUSIONS

No benefits are available under the dental benefits of this Plan for the following:

1. Cosmetic Services. Services performed solely for cosmetic purposes.
2. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
3. Excess Charges. Charges more than the Usual, Customary and Reasonable charge.
4. Hygiene. Oral hygiene education, plaque control programs or dietary instructions.
5. Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
6. Medical services. Services that, to any extent, are payable under any Medical Benefits of this Plan.
7. Orthognathic surgery.
8. Personalization of dentures.
9. Replacement. Replacement of lost or stolen appliances.
10. Charges for root canal therapy for which the pulp chamber was opened before the effective date of coverage under this Plan.
11. Services not stated. Services that are not included in the list of covered dental services.
12. Services Prior to Coverage. Services or treatment incurred prior to the effective date of coverage under this Plan.
13. Temporomandibular Joint Dysfunction (TMJ). Any treatment and services in connection with malocclusions or other abnormalities of the jaw, including services for temporomandibular joint disorders and myofascial pain syndrome or any related appliances.
14. Untimely Claims. Services for which a claim is not filed with this Plan within 180 days of the date the service was incurred unless it was reasonably impossible for the claim to be filed within 180 days.

SECTION 6
DEFINED TERMS

The following definitions shall apply to the terms listed below. The masculine includes the feminine and the singular includes the plural.

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.

AMENDMENT - Shall mean any Amendment attached hereto and made a part of the Plan which operates to change and supersede any of the terms or conditions set forth in the printed Plan.

APPLICATION FOR ENROLLMENT - Shall mean an Enrollment Form which shall be completed by the employee, giving the legal name, legal relationship, birth date, sex and medical history, if required, of every family member for whom coverage is to be provided. Enrollment Forms shall be signed and dated by the employee.

CALENDAR YEAR - The period of time beginning with the covered individual's most recent date of enrollment and ending December 31 of that year. Each succeeding 12 month period will constitute a new Calendar Year beginning January 1, and ending each succeeding December 31.

COSMETIC SURGERY - Surgery done solely for aesthetic improvement.

COVERED SERVICES - Only those benefits or services listed in this document and not excluded by the terms of the Plan.

DEDUCTIBLE is the amount of covered expenses for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the Annual Deductible, if any, as listed in the ***Schedule of Benefits Section.*** An individual Deductible needs to be satisfied only once per Calendar Year, regardless of the number of Illnesses or Injuries. The deductible applies separately to each Covered Person, but no Family Unit will be required to satisfy more than the total Family Unit deductible as listed in the ***Schedule of Benefits Section.*** This Plan will pay benefits after any required Deductibles are satisfied.

The Plan Administrator may allocate any Deductible amounts to any eligible charges and apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding on the Covered Person and all assignees.

ELIGIBLE DEPENDENT - Is any one of the following persons:

1. The employee's legal spouse;

2. An unmarried child of the employee under 19 years of age, living with the employee; or

   An unmarried child of the employee, who is less than 23 years of age, and is attending an accredited educational institution or accredited trade school as a full time student and who resides with the insured. The child must also be claimed on the employee's U.S. Individual Income Tax Return.

There are three exceptions to the residency requirement. One is when the child is attending school and the second is when the employee is required by court order to provide health insurance coverage. The third is when the employee divorces the other parent. Then, the child may be covered by both parents, if the child meets the dependency requirements of at least one of the parents.

The terms "child" or "children" include: A natural child of the employee; a stepchild living in the employee's home; a grandchild or an adopted child (a child who has been legally adopted by the employee).

Also, with approval of the Plan Administrator, a future employee may enroll a child over age 19, who is not eligible but who has been continuously incapable of self-sustaining employment prior to reaching age 19, because of mental retardation or physical handicap.

ELIGIBLE EMPLOYEE - A regular employee scheduled to work 30 hours, or more, per week, and who is "actively at work" on the date coverage is to begin.

FAMILY UNIT is the covered Employee and his/her family members who are covered as Dependents under the Plan.

INCUR - Means an eligible expense you or your family member becomes obligated to pay. The expense of a service is incurred on the day the service is rendered. The expense of a supply is incurred on the day the supply is delivered to you or your covered family member.

MEDICARE - Means the two programs established by Title I of Public Law 89-98 (79 statutes 286-343), known as the Health Insurance for the Aged Act, which includes Part A- Hospital Insurance Benefits for the Aged; Part B- Supplementary Medical Insurance Benefits for the Aged; and Part C- Miscellaneous provisions regarding both programs, and also including any subsequent charges or additions to those programs.

MEDICARE BENEFITS - Means those benefits actually provided under any part of Medicare to an individual having entitlement who made claim or the equivalent of those benefits for which the employee would have been eligible had he established and maintained his entitlement, paid any required premium, and made claim.

PALLIATIVE CARE - Means care primarily for the relief or control of distressing symptoms, not cure.

PLAN YEAR - Shall mean the period of 12 months beginning with the initial effective date of the Plan.

PROFESSIONAL PROVIDERS - This Plan will provide benefits for covered services provided by the following categories of providers when practicing within the scope of their license, and subject to the limitations and provisions of this Plan:

1. A dentist (D.D.S. or D.M.D.);
2. A licensed denturist; and
3. A certified dental hygienist

THIRD PARTY AND MOTOR VEHICLE CLAIMS - An illness or injury resulting from the neglect or wrongful act or omission of another party or parties, or resulting from accidental injury involving a motor vehicle, or resulting from any situation in which there is responsibility from a source other than this Plan.

UCR (Usual, Customary and Reasonable) - The normal and reasonable charges for services, supplies, treatment and advice. The charges must be the providers regular charge and must fall within the usual, customary and reasonable range of charges prevailing in that geographical area for like services as determined by the company retained to provide such information for this Plan.

WORKERS COMPENSATION CASE - An injury or occupational disease arising out of or in the course of employment or self-employment for which benefits could be made available from the government, any governmental agency, an insurance carrier, self-insured employer funded program, or any other agency, had proper application for such benefits been made.

SECTION 7
CLAIMS PROCEDURES

HOW TO FILE A CLAIM

Most dental providers will direct bill the Claims/Contract Administrator for their services. If a provider does not direct bill the Contract/Claims Administrator, obtain an itemized billing for the services (balance forward statements are not acceptable). All claims submitted for payment must include:

1. The name of the Covered Employee;
2. Member ID number of the Covered Employee;
3. Full name and date of birth of the patient;
4. Procedure Code;
5. Date of Service; and
6. Charge(s) for the service.

Send the above information to the Contract/Claims Administrator at this address:
ARM, Ltd
814 W Northwest Hwy
Arlington Hts IL 60004

WHEN CLAIMS SHOULD BE FILED

Written notice and proof of loss must be given to the Plan Administrator or his designated Contract/Claims Administrator within 180 days after the occurrence or commencement of any loss covered by this Plan. Benefits are based on the Plan's provisions at the time the charges were incurred. Charges are considered incurred when a treatment or care is given or a procedure performed. Failure to give such notice and proof within 180 days will neither invalidate nor reduce any claim if it is shown that:

1. It was not reasonably possible for the claimant to give written notice and proof within 180 days; and
2. Written notice and proof are given as soon as reasonably possible, but in no case later than one year after the loss occurs or commences, unless the claimant is legally incapacitated.

Upon termination of the Plan, final claims must be received within 60 days of the date of the termination of the Plan.

CLAIMS PROCESSING PROCEDURES

The Contract/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 Plan Participant seek a second medical opinion.

All claims submitted to the Plan will be subject to a full and fair review.

If a claim is wholly or partially denied, the Contract/Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 60 days after receipt of the claim. The written notice will contain the following information:

1. The specific reason or reasons for the denial including reference to the Plan provisions upon which the denial is based;

2. A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

3. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 60 days of receipt of the claim as to the acceptance or denial of a claim.

If special circumstances require an extension of time for processing the claim, the Contract/Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 60 days from the end of the initial 60 day period.

HOW TO APPEAL A CLAIM DENIAL

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. The Plan Participant must file the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim. Such request must include the name of the Employee, his or her Social Security number, and the name of the patient.

The request for review must be directed to the Plan Administrator or the Contract/Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

LEGAL PROCEEDINGS

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. No action at law or in equity shall be brought to recover benefits under the Plan prior to the expiration of 60 days after proof of loss has been filed in accordance with the Claims Procedures provision of this Plan.

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, this Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be requested to refund the overpayment. If the refund is not received from the Covered Person, the amount of the overpayment will be deducted from future benefits. Similarly, if payment is made on the behalf of a Covered Person to a Hospital, Physician or other health care provider, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

SECTION 8
COBRA CONTINUATION COVERAGE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under this 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 Plan Participants 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.

The Plan Administrator is Cardinal Services, Inc. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan 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 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 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 Plan participant 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.

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. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, 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, which does not impose such pre-existing condition exclusions. 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 not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 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.

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 dependents 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 and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax 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.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? This 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 Human Resources department or firm listed below, at the following address:

Cardinal Services, Inc.
110 Ackerman
Coos Bay, OR 97420

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 (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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 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.

5. 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).

6. 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.

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- 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.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan 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.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. 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.

SECTION9
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 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.

When an individual is covered under more than one plan, one plan normally pays its benefits in full and the other plan or plans pay a reduced amount. This Plan will always pay its benefits in full or a reduced amount, if any, that when added to the benefits payable by the other plan or plans will not exceed 100% of the allowable expenses. Only the amount paid by this Plan will be charged against the Plan Benefit Maximums of this Plan.

Benefit plan. This Coordination of Benefits provision will coordinate the health and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans, without limitations:

1. Group insurance or any other arrangement for coverage for covered persons in a group whether on an insured or uninsured basis, including but not limited to hospital indemnity benefits and hospital reimbursement type plans;

2. Hospital or medical service organizations on a group basis, group practice and other group pre• payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. A licensed Health Maintenance Organization (HMO);

5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

6. Any coverage under a Government program, and any coverage required or provided by any statute;

7. Group automobile insurance;

8. Individual automobile insurance coverage on an automobile leased or owned by the Company;

9. Individual automobile insurance coverage based upon the principles of "no-fault" coverage;

10. Any plans or policies funded in whole or in part by an employer or deductions made by an employer from a person's compensation benefits; or

11. Labor/management trusteed, union welfare, employer organization or Employee benefit organization.

Coordination of Benefit Procedures. When this Plan is determined to be a secondary plan as to one or more other plans, the benefits of this Plan may be reduced. The benefits of this Plan will be reduced when the sum of:

1. The benefits that would be payable for the allowable expenses under this Plan in the absence of this Coordination of Benefits provisions; and

2. The benefits that would be payable for the allowable expenses under the other plan or plans in the absence of provisions with a purpose like that of this Coordination of Benefits provision, whether or not a claim is made;

exceeds those allowable expenses in a claim determination period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plan or plans do not total more than those allowable expenses. When the benefits of this Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, the following rules will apply, if Medicare is not involved:

1. Plans that do not have a Coordination of Benefits provision, or state that its coverage is primary, will pay first;

2. Plans with a Coordination of Benefits provision will pay their benefits by the following rules:

   a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) is primary and will pay its benefits first;

   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 that 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 parent's plan that has covered the child for the longer time will be considered the child's primary coverage.

   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) 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) If there is still a conflict after these rules have been applied, the benefit plan which has covered the child for the longer time will be considered first.

Coordination with Medicare. 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.

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

SECTION 10
THIRD PARTY RECOVERY PROVISIONS

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to injuries that may be caused by the act or omission of a third party. 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 that 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.

Defined terms. "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Illness whether or not said losses reflect medical or dental charges covered by the Plan.

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

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

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 priority over any funds paid by a third party to a Covered Person relative to the Injury or Illness, including a priority over any claim for non-medical (health) or dental charges, attorney fees, or other costs and expenses.

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 health or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

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.

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, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Assignment of Rights. As a condition to the Plan making payments for any medical or dental charges, the Covered Person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the Injury or Illness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

SECTION 11
HIPAA PRIVACY PROVISIONS

This section describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose "Protected Health Information". The following HIPAA definitions apply to the provisions of this Plan:

- **Protected health information** (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. Protected health information includes information of persons living or deceased.

- **Plan Sponsor** means the Employer as defined in this document.

- **Plan** (also referred to as "GHP") means the Group Health Plan for the Employees of the Employer as defined in this document.

- **Plan Documents** means the GHP's governing documents and instruments such as documents under which the GHP was established and is maintained.

This Plan is required by law to maintain the privacy of protected medical information and to provide covered individuals with notice of its legal duties and privacy practices with respect to protected medical information. However, the Plan is permitted to use and disclose this information under the circumstances described below.

This Plan is required to abide by the terms of this information until it is amended. This Plan reserves the right to change the terms of its privacy practices and to make new notice provisions effective for all protected health information that it maintains. All individuals covered under this Plan will receive a notice within 60 days of a material revision to this information.

In order for this Plan to pay for your covered medical expenses, this Plan and those administering the Plan must create or receive certain medical information about you. This information may involve:

- **Payment activities** such as billing and collection activities, eligibility determinations, adjudication of claims, precertification and utilization review, and coordination of benefits, or

- **Health care operation activities** such as quality assessment, case management, subrogation or business management and general administrative activities, or
- **Treatment activities** by your health care provider, such as providing information about other treatments you have received.

By enrolling in this plan, you have agreed to allow this Plan and its administrators to create or use your medical information in order to perform these duties without your express authorization. This Plan may also disclose medical information about you without your authorization to business associates of the plan, such as actuaries who price the cost of coverage, the Claims Administrator who pays the claims or other professionals who perform services on behalf of the Plan. All disclosures made by this Plan of medical information for purposes of payment or health care operation activities shall be the minimum necessary to accomplish the intended purpose of the disclosure, and any business associate who receives the information must agree to keep it confidential.

This Plan may be required to make available to the Department of Health and Human Services all books and records regarding the health information of Covered Persons if this information is requested for audit purposes. You will not have to authorize this disclosure.

This Plan may disclose information about your medical records to a medical professional treating you. No authorization is necessary for this disclosure.

The law requires this Plan to make certain disclosures. These include disclosures:

- As necessary to comply with workers compensation or other similar programs.

- As necessary for courts and law enforcement agencies. Disclosures to a law enforcement agency may occur if required by law (such as the occurrence of certain types of wounds) or if required by a court order or other legal process. The Plan may also disclose medical information: for the purpose of identifying or locating a suspect, witness, fugitive or missing person; about a crime victim, if the victim agrees or emergency circumstances require disclosure without consent; about a person who has died if the nature of the death suggests that it may be the result of criminal conduct; or if there is evidence to suggest that a crime occurred on the premises.

- As necessary for public health research and disclosure, including reporting of communicable diseases to the applicable authorities (who may contact exposed individuals) and workforce medical investigations.

- As necessary to a health oversight agency for oversight activities authorized by law. However, this will generally not include an investigation of a particular individual unless it involves receipt of health care, public health benefits or public benefits contingent on the individual's health.

- As necessary if disclosure is required by another law.

This Plan may also be permitted or required to disclose medical information without your authorization under the following circumstances:

- If authorized by law, to the proper authorities for purposes of reporting child abuse or domestic violence. Subject to certain restrictions, the Plan may also report this information to social services, but must generally inform the victim of the abuse that it is making the disclosure.

- To people working for or with the Food and Drug Administration. These disclosures may be necessary: to report adverse events with respect to food or dietary supplements, product defects (including use or labeling defects), or biological product deviations; for product tracking; to enable product recalls, repairs or replacements; or to conduct post marketing surveillance.

- Upon your death, to a coroner, funeral director or to tissue or organ services, as necessary to permit them to perform their functions.

- Under certain circumstances, for research purposes.

- To prevent or lessen a serious threat to the health or safety of a person or the public.

- If authorized by law, in connection with military matters or matters of national security and intelligence.

In addition, this Plan may disclose medical information to the Plan Sponsor under the following conditions:

- The Plan Sponsor may not use any such information for employment-related decisions.

- The Plan Sponsor may receive such information as the Plan documents allow.

- You have the right to inspect the Plan documents allowing disclosures.

Other uses and disclosures of your medical information will be made only with your written authorization and you may revoke the authorization at any time, upon request.

You have the right:

- To request restrictions on certain uses and disclosures of your medical information. The Plan does not have to agree with a requested restriction, but if the Plan does agree, then the Plan will abide by that restriction.

- To receive your own confidential health information by alternative means or at alternative locations, if receipt of the information in the usual manner could endanger you, contact the Employers Privacy Officer to request the alternative delivery. You must include a statement that disclosure of the information in the usual manner could endanger you.

- To inspect and copy your own health information, but exceptions apply to certain types of information. If you request to see or copy your own health information from the Plan Administrator and one of these exceptions apply, you will be given more information at that time, including the circumstances under which you may challenge the exception.

- To amend your own health information when that information is incorrect.

- To obtain an accounting of any disclosure of your confidential health information, other than disclosures for purposes of payment, health care operations or treatment, or disclosures made in accordance with your written authorization.

In each case, you must make your request to the Plan Sponsor, in writing. Depending upon the nature of the request, you will be given more information at that time, including any exceptions to the rules that may apply to your case.

Individuals may complain to the Plan Sponsor and/or to the Secretary of Health and Human Services if they believe their privacy rights have been violated. If you wish to file such a complaint, please contact the Plan Sponsors Privacy Officer and you will be given information on how to proceed. You will not be retaliated against by the Plan or Plan Administrator for the complaint. The Department of Health and Human Services may be contacted in Washington, DC or listings may be found in local telephone directories.

SECTION 12
STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

2. 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.

3. To receive a summary of the Plan's annual financial report which the Plan Administrator furnishes to each participant.

4. To continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event.

5. A 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, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

6. To file suit in a Federal court if any materials requested are not received within thirty (30) days of the request unless notified that the materials were not sent because of matters beyond the control of the Plan Administrator.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan (the Fiduciaries). Fiduciaries have a duty to operate the Plan prudently and in the interest of the Plan Participants and their beneficiaries.

No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining a welfare benefit or exercising rights under ERISA.

If a Participant is improperly denied a welfare benefit in whole or part, he has the right to file suit in a Federal or State court. If Plan fiduciaries are misusing the Plan's money, he shall have the right to file suit in a Federal court or request assistance from the U.S. Department of Labor. If successful in such lawsuit, the court may, if it so decides, require the other party to pay his legal costs, including attorney's fees.

If the Plan Participant has any questions about this statement or his or her rights under ERISA, that Plan Participant should contact either the nearest area office of the U.S. Pension and Welfare Benefits Administration, Department of Labor listed in the telephone directory or the Division of Technical

Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW Washington, DC 20210. Telephone number (202) 219-8776.

SECTION 13
GENERAL PLAN INFORMATION

Name of Plan:
Cardinal Services, Inc. Employee Dental Plan

Plan Number:
502

Type of Plan:
Group Dental Employee Welfare Plan

Employer/Plan Sponsor:
Cardinal Services, Inc.
110 Ackerman
Coos Bay, OR 97420
Telephone 541-888-9799

Plan Administrator/Named Fiduciary:
Cardinal Services, Inc.
110 Ackerman
Coos Bay, OR 97420
Telephone 541-888-9799

Agent of Legal Service:
Cardinal Services, Inc.
110 Ackerman
Coos Bay, OR 97420

Administration:
Self-Administered by the Employer - The Employer has appointed a Claims Administrator to handle the day to day operation of the Plan.

Claims/Contract Administrator
ARM, Ltd.
814 W Northwest Hwy
Arlington Hts IL 60004
Telephone: 847-394-1700 Toll-Free: 800-392-1770

Employer Identification Number
93-0920470