

# **Case Western Reserve University Benelect Plan *Dentemax Dental Insurance Plan Summary***

**Originally Effective: January 1, 2000**

**Amended and Restated Effective: January 1, 2012**



P.O. Box 22033  
Lansing, MI 48909-2033  
(800) 321-4085  
[www.meritain.com](http://www.meritain.com)

# TABLE OF CONTENTS

DENTAL SCHEDULE OF BENEFITS.....	1
ELIGIBILITY FOR PARTICIPATION.....	2
TERMINATION OF COVERAGE.....	7
DENTAL EXPENSES.....	9
DENTAL EXCLUSIONS AND LIMITATIONS.....	13
COBRA CONTINUATION COVERAGE.....	15
CLAIM PROCEDURES.....	18
COORDINATION OF BENEFITS.....	23
SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT.....	28
DEFINITIONS.....	31
PLAN ADMINISTRATION.....	37
MISCELLANEOUS INFORMATION.....	39
STATEMENT OF ERISA RIGHTS.....	41
HIPAA PRIVACY PRACTICES.....	43
HIPAA SECURITY PRACTICES.....	45
GENERAL PLAN INFORMATION.....	46

## DENTAL SCHEDULE OF BENEFITS

BENEFIT	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER (Subject to Usual and Customary Charges)
<b>CALENDAR YEAR DEDUCTIBLE</b>		
Single	None	\$50
Family	None	\$100
<b>TYPE I, II AND III EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT</b>	\$1,500 per Covered Person	
<b>TYPE IV ORTHODONTIC* LIFETIME MAXIMUM BENEFIT</b> (Coverage is provided only for Children under age 19)	\$1,250 per Covered Person	\$800 per Covered Person
<b>DENTAL BENEFITS</b>		
Type I-Preventive Services	100%	70% after Deductible
Type II-Basic Services	80%	60% after Deductible
Type III-Major Services	60%	40% after Deductible
Type IV-Orthodontic Services* (Coverage is provided only for Children under age 19)	50%	35% after Deductible

**\*NOTE: To be eligible for Type IV-Orthodontic Services, you must be a Covered Person in The Case Western Reserve University DenteMax Dental Plan for a period of 12 consecutive months prior to the period for which expenses are payable.**

**NOTE: The dental benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. You have a separate right to enroll in the dental benefits under the Plan. If you choose to enroll in such dental benefit, you will be charged an employee contribution amount that is separate from what you are charged for any other benefit offered under the Plan. The amount of any employee contribution will be communicated to you by the Plan Administrator prior to the annual open enrollment period.**

## ELIGIBILITY FOR PARTICIPATION

### Employee Eligibility

An existing Eligible Employee who has executed an Earnings Reduction Agreement or other required enrollment form shall become a Participant on the first day of the start of the next Plan Year. The participation of a newly hired Eligible Employee shall commence, following the Eligible Employee's execution of an Earnings Reduction Agreement or other required enrollment form, on the earlier of 1) the first day of the month coincident with or next following the date of hire, or 2) if the Eligible Employee's date of hire is the first business day of the month, such Eligible Employee shall commence participation on his date of hire. In addition to the requirements of this Section, an Eligible Employee must satisfy the eligibility provisions of any Benefit Plan.

You are eligible to enroll in the Plan upon employment provided you are not covered under any other Dental Care Plan offered by another company. Please refer to the Coordination of Benefits section of the Plan for further details.

You are not eligible to participate in the Plan if you are a temporary, leased or seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law Employee by a court or governmental agency).

### Dependent Eligibility

Your Dependents are eligible for participation in this Plan provided he/she is:

- (1) Your spouse or spouse equivalent.
- (2) Your Dependent Child until the end of the month in which he/she attains age 26.
- (3) Your Dependent Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. Your Dependent Child must be unmarried and primarily dependent upon you for support. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Dependent Child's physical or mental incapacity.
- (4) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

"Dependent Child" means the Participant's biological child, stepchild, adopted child or foster child, and:

- (1) is under the age of 26;
- (2) is age 26 or older, disabled and incapable of independent living, provided that either (a) the child became disabled prior to age 26 and remains disabled while receiving coverage under the Plan, or (b) the physical or mental impairment is a result of either a congenital or acquired illness or injury.

Health care coverage will also be provided pursuant to this Plan to any child pursuant to a Qualified Medical Child Support Order or if state law requires a non-qualifying court order or because of an administrative order of any state agency.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Eligible Foster Child" shall mean an individual who is placed with you by an authorized placement agency.

### **When you and your spouse are both Covered Employees**

When both you and your spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent.

### **Court Ordered Coverage for a Child**

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

### **Timely Enrollment**

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide a written statement to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

### **Open Enrollment Period**

You and your Dependents may enroll for coverage during the Plan's open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of January 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

***Please note: If you drop Dental Coverage during the open enrollment period, you will not be eligible to select Dental Coverage again for two (2) years.***

### **Late Enrollment**

If you did not enroll during your original 30-day eligibility period you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

## Special Enrollment Event

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

- (1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:
  - (a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;
  - (b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or
  - (c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

- (2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or SCHIP coverage terminates or after your or your Dependents' eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.

- (3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.
  - (a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the child's birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.

- (b) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after your date of marriage. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.
- (c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

### **Status Change Event**

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

- (1) A change in your legal marital status, including divorce, legal separation or annulment;
- (2) The death of your spouse or Dependent Child;
- (3) Termination or commencement of employment by you, your spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (4) A reduction or increase in your hours of employment or those of your spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;
- (5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;
- (6) A change in the place of residence or work of you, your spouse or your Dependent Child;
- (7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your spouse or your Dependent Child;
- (8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;
- (9) A change due to you, your spouse or your Dependent Child gaining coverage under another employer's plan;
- (10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;
- (11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;
- (12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

- (13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and
- (14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the Status Change Event. Coverage under the Plan will become effective on the date you submit the appropriate election and enrollment forms to the Plan Administrator.



## TERMINATION OF COVERAGE

### Termination of Employee Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;
- (4) The end of the month in which you cease to be eligible for coverage under the Plan;
- (5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;
- (6) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and
- (7) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

### Termination of Dependent Coverage

Coverage under the Plan will terminate on the earliest of the following dates:

- (1) The date the Plan terminates, in whole or in part;
- (2) The date the Plan discontinues coverage for Dependents;
- (3) The date your Dependent becomes covered as an Employee under the Plan;
- (4) The date coverage terminates for the Employee;
- (5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;
- (6) The date the Dependent spouse or the spouse equivalent of an Employee reports to active military service;
- (7) The end of the month in which a Dependent ceases to be a Dependent as defined by the Plan;
- (8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and
- (9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

### Retroactive Termination of Coverage

Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

### **Continuation of Coverage under the Family and Medical Leave Act (FMLA)**

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

### **Continuation of Coverage under State Family and Medical Leave Laws**

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

### **Continuation of Coverage under USERRA**

You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

# DENTAL EXPENSES

## Dental Participating Provider Organization

The Plan includes an arrangement with a Dental Participating Provider Organization (PPO). The Dental PPO name, address and phone number will be printed on the Employee identification card. The Dental PPO will apply to all Family members regardless of where the individual Family members may reside. The Plan Administrator will provide each Employee with information regarding his or her Dental PPO.

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

- (1) Constitute Dentally Necessary treatment.
- (2) Are Incurred while covered under this Plan.
- (3) Are Usual and Customary Charges for Non-Participating Providers.

The Plan will pay for such eligible expenses as shown in the Dental Schedule of Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

- (1) Referral is made by a Participating Provider to receive services from a Non-Participating Provider.
- (2) Covered Person has an emergency situation for the alleviation of pain and services cannot be rendered by a Participating Provider.
- (3) Services provided in The University Dental Clinic. Services rendered in The University Dental Clinic by students working under the supervision of a licensed Dentist are reimbursable at the Participating Provider level of benefits. Refer to the Dental Schedule of Benefits for coverage information.

## Deductible – Non-Participating Providers Only

A Deductible is the total amount of eligible expenses as shown in the Dental Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one (1) individual Deductible amount to a family Deductible.

## Date Expenses are Incurred

An expense is Incurred when the service is performed, except that it is deemed to be Incurred:

- (1) When the impression is taken in the case of dentures or fixed bridgework;
- (2) When preparation of the tooth is begun in the case of crown work;
- (3) When the pulp chamber is opened in the case of root canal therapy.

## Alternative Treatment

The Plan has an "alternate treatment" clause that limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

### **Benefits After Termination**

Benefits are not payable after a Covered Person's coverage terminates. However, if a Covered Person's coverage terminates (for reasons other than the termination of The Case Western Reserve University DenteMax Dental Plan itself), benefits will be payable with respect to:

- Root canal therapy where the work is begun prior to the date of termination.
- Dentures, fixed bridgework, or crowns ordered prior to the date of termination.

"Ordered" means preliminary planning and preparation has been completed. For a denture, this means impressions have been taken from which it will be prepared. For the other items noted, this means the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item and impressions have been taken from which it will be prepared.

In no event shall such benefits be payable for Covered Expenses rendered more than 60 days after the date a person's coverage terminates.

### **Eligible Dental Expenses**

The following is a list of dental procedures covered under this Dental Expense benefit.

#### **Type I-Preventive Services**

- (1) Routine oral examinations but not more than twice in any period of 12 consecutive months.
- (2) Topical application of Fluoride.
- (3) Routine scaling and polishing of teeth, but not more than twice in any period of 12 consecutive months.
- (4) Full mouth x-rays but not more than once in any period of 36 consecutive months.
- (5) Supplementary bitewing x-rays but not more than two (2) series in 12 consecutive months.
- (6) X-rays as required in connection with the diagnosis of a specific condition requiring treatment except x-rays provided in connection with Orthodontic diagnostic procedures and treatment.
- (7) Space maintainers that replace teeth lost prematurely due to disease for Dependent Children under 19 years of age.
- (8) Initial application of occlusal sealants for Dependent Children under age 13.
- (9) Emergency palliative treatment.

#### **Type II-Basic Services**

- (1) Simple extractions.
- (2) Amalgam, silicate, acrylic, porcelain, and composite filling restorations to restore diseased or fractured teeth.
- (3) Treatment for accidental Injury to natural teeth.
- (4) Injection of antibiotic drugs by the attending Dentist.
- (5) Oral Surgery.
- (6) Treatment of diseases of the gums and other tissues of the mouth including periodontal prophylaxis (cleaning) which may be performed three (3) times in any period of 12 consecutive months.
- (7) Endodontic treatment (those procedures usually employed for prevention and treatment of diseases of the dental pulp and the area surrounding the tip of the tooth root), including root canal therapy.

- (8) Repair or recementing of crowns, inlays, onlays, bridgework, or dentures; or relining or rebasing of dentures more than six (6) months after the installation of an initial or replacement denture, but not more than one (1) relining or rebasing in any period of 36 consecutive months.
- (9) Administration of anesthetics when Medically Necessary, except local infiltration anesthetic provided either in or out of a hospital, and administered in connection with oral or dental Surgery. Benefits are not provided for substances or agents which are administered to produce a state of sedation or relaxation or to minimize fear or reduce or eliminate pain while the patient is conscious, unless the patient is handicapped by cerebral palsy, mental retardation, or spastic disorders.

### **Type III-Major Services:**

- (1) Initial installation of fixed bridgework to replace missing natural teeth (including inlays and crowns as abutments except periodontal splinting).
- (2) Initial installation of partial or full removable dentures to replace missing natural teeth and adjacent structures (including precision attachments which can be justified as functionally necessary with study models and radiographs). Includes adjustments for the six (6) month period following installation.
- (3) Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework, but only if satisfactory evidence is presented that:
  - (a) the replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed; or
  - (b) the existing denture or bridgework cannot be made serviceable and at least five (5) years have elapsed prior to its replacement; or
  - (c) the existing denture is an immediate temporary denture which cannot be made permanent and placement by a permanent denture takes place within 12 months from the date of initial installation of the immediate temporary denture.

***Note: Normally, dentures will be replaced by dentures, but if a professionally adequate result can be achieved only with bridgework, such bridgework will be a Covered Expense.***

- (4) Inlay, onlays, gold fillings, or crown restorations to restore diseased teeth but only when the tooth, as a result of caries, cannot be restored with an amalgam, silicate, acrylic, porcelain, or composite filling restoration.
- (5) Implants including any appliances and/or crowns, and the surgical insertion and/or removal of an implant.

### **Restorative Limitations:**

- (1) Gold or Porcelain Restorations and Crowns

If a tooth can be restored with a material such as amalgam, payment of the applicable percentage for that procedure will be made toward the charge for another type of restoration selected by you and your Dentist. The balance of the treatment charge remains your responsibility.

Replacement of crowns will be a covered dental expense only if at least five (5) years have elapsed since the date of the initial installation of that crown.

- (2) Partial Dentures

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure will be made toward a more elaborate or precision appliance that you and your Dentist may choose to use, and the balance of the cost remains your responsibility.

(3) Complete Dentures

If, in the provision of complete denture services, you and your Dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the cost of the standard denture services will be made toward such treatment, and the balance of the cost remains your responsibility.

(4) Replacement of Existing Dentures

Replacement of an existing denture will be a covered dental expense only if the existing denture is unserviceable and cannot be made serviceable. Payment based on the applicable percentage will be made toward the cost of services which are necessary to render such appliances serviceable. Replacement of prosthodontic appliances will be a covered dental expense only if at least five (5) years have elapsed since the date of the initial installation of that appliance under this Plan.

(5) Reconstruction

Payment based on the applicable percentage will be made toward the cost of procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to alter vertical dimension in restoring occlusion are considered optional and their cost is your responsibility.

**Type IV-Orthodontic Services:**

Orthodontic diagnostic procedures (including examinations and x-rays) and treatment consisting of appliance therapy and surgical therapy to correct malocclusion for Dependent Children under 19 years of age.

***Note: To be eligible for Orthodontic expenses, you must be a participant in the DenteMax Dental Plan for a period of 12 consecutive months prior to the period for which expenses are payable.***

## DENTAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

- (1) Services other than those specifically covered herein.
- (2) Charges for any dental services and supplies which are covered in whole or in part under any other Plan or benefits provided by the Employer.
- (3) Charges for treatment by other than a Dentist or a Graduate Student Dentist of the Case Western Reserve University Dental Clinic, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed Dental hygienist if the treatment is rendered under the supervision and guidance of the Dentist and billed by the Dentist.
- (4) Charges for services or supplies that are Cosmetic in nature, including charges for personalization or characterization of dentures.
- (5) Services rendered or provided prior to the effective date of coverage.
- (6) Services Incurred after coverage termination.
- (7) Charges for prosthetic devices including bridges, crowns, inlays and onlays, and the fitting thereof that were ordered while the individual was not covered for Dental expense benefits, or that were ordered while the individual was covered for Dental expense benefits but are finally installed or delivered to such individual more than 60 days after termination of coverage.
- (8) Charges for the replacement of a lost, missing or stolen prosthetic device.
- (9) Charges for any duplicate prosthetic device or any other duplicate appliance.
- (10) Charges for oral hygiene, dietary instructions, plaque control and other educational programs.
- (11) Dentures, crown, inlays, onlays, bridgework and other appliances or services intended to increase vertical dimension or restore occlusion.
- (12) Charges for bite splints and/or occlusal guards.
- (13) Treatment of temporomandibular joint (TMJ) syndrome.
- (14) Charges for drugs or medications.
- (15) Services for which the individual is not required to make payment or for which no charge would be made in the absence of coverage under the DenteMax Dental Plan.
- (16) Services for which payment or reimbursement is received by or for the account of the individual as a result of legal action or settlement.
- (17) Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth, other than the 10 upper and lower anterior teeth.
- (18) Charges for services or supplies furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
- (19) Charges for services or supplies for which benefits are furnished, paid for, or for which benefits are provided or required by any law of a government. (This does not include a plan established by a government for its own employees or their dependents).

- (20) Treatments which are for an Illness or Injury occurring in the course of employment if whole or partial benefits or compensation are available under the Workers' Compensation Act or any similar law. This applies whether or not the Covered Person claims such compensation or recovers losses from a third party.
- (21) Treatment for any Injury resulting from or occurring during your commission of a felony.
- (22) Treatment for Illness or Injury that occurs as a result of any act of war.
- (23) Charges for services or supplies which are not Medically Necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending Dentist.
- (24) Charges for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental and/or Investigational in nature.
- (25) Charges for services provided in an Inpatient Hospital setting. (These expenses may be considered for coverage under your Medical Plan.)

**Integration with Medical Benefits**

In the event benefits are available for the same expenses under both a medical plan offered by the Employer and the dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses and only up to the excess amount.



## COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event".

### Qualified Beneficiary

In general, you, your spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A spouse equivalent of an Employee, generally is not entitled to continue coverage under COBRA; however the Plan Sponsor has chosen to extend COBRA-like coverage to the spouse equivalent and to the child of a spouse equivalent. COBRA-like coverage is identical to a continuation of coverage under COBRA offered to a spouse and any Dependent Child of an Employee.

If the qualifying event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, a covered Retiree and his or her covered spouse, surviving spouse or Dependent Child of such Retiree will also be considered qualified beneficiaries provided the bankruptcy results in the loss of their coverage under the Plan.

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) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

### Qualifying Event

If you are a covered Employee, you, your spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced or
- (2) Your employment ends for any reason other than your gross misconduct.

You, your spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events:

- (1) Your spouse/parent-Employee dies;
- (2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or
- (3) You/your parents become divorced or legally separated.

Your spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and

their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of; (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

### **Extension of 18-Month Continuation Coverage Period**

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61<sup>st</sup> day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

### **Notice Requirement**

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

- (1) Name and address of the covered Employee or former employee;
- (2) Name and address of your spouse, former spouse and any Dependent Children;
- (3) Description of the qualifying event; and
- (4) Date of the qualifying event.

In addition to the information above, if you, your spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

- (1) Name of person deemed disabled;
- (2) Date of disability determination; and
- (3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Meritain Health, Inc.  
P.O. Box 27158  
Lansing, MI 48909-7158  
Fax No.: (716) 319-5736

### **Termination of COBRA Continuation Coverage**

COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

- (1) The date the Plan Sponsor ceases to provide any group health plan coverage;
- (2) The date on which the qualified beneficiary fails to pay the required contribution;
- (3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Condition limit that affects that individual; he/she will be allowed to continue COBRA continuation coverage for the length of the pre-existing condition or to the COBRA maximum time period, if less; or
- (4) The first day of the month that begins more than 30 days after the date of the SSA's determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

### **Payment for COBRA Continuation Coverage**

Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

### **Additional Information**

Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Information page of this Plan.

### **Current Addresses**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

## CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.  
P.O. Box 22033  
Lansing, MI 48909-2033  
(800) 321-4085

Most claims under the Plan will be "post service claims." A "post service claim" is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

- (1) The date of service;
- (2) The name, address, telephone number and tax identification number of the provider of the services or supplies;
- (3) The place where the services were rendered;
- (4) The diagnosis and procedure codes;
- (5) The amount of charges (including Network repricing information);
- (6) The name of the Plan;
- (7) The name of the covered Employee; and
- (8) The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

### Timely Filing

All claims must be filed with the Third Party Administrator within 24 months following the date services were Incurred. Claims filed after this time period will be denied.

### Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are four (4) different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

- (1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail

to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim.

- (2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- (3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- (4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

### **Manner and Content of Notice of Initial Adverse Determination**

If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

- (1) An explanation of the specific reasons for the denial;
- (2) A reference to the Plan provision or insurance contract provision upon which the denial is based;
- (3) A description of any additional information or material that you must provide in order to perfect the claim;
- (4) An explanation of why the additional material or information is necessary;
- (5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
- (6) A statement describing your right to bring an action for judicial review under ERISA Section 502(a);
- (7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
- (8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than three (3) days after the oral notification.

### **Internal Review of Initially Denied Claims**

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

- (1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.
- (2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
- (3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.
- (4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

- (5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.  
Appeals Department  
P. O. Box 1380  
Amherst, NY 14226-1380

#### **Deadline for Internal Review of Initially Denied Claims**

- (1) **Urgent Care Claims.** For urgent care claims, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review of an initial adverse determination by the Plan.
- (2) **Pre-Service Claims.** For a pre-service claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination.
- (3) **Post-Service Claims.** For a post-service claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives your request for review of the initial adverse determination.

#### **Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims**

Upon completion of its review of an initial adverse determination, the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

- (1) A description of the Plan's decision;
- (2) The specific reasons for the decision;
- (3) The relevant Plan provisions or insurance contract provisions on which its decision is based;
- (4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
- (5) A statement describing your right to bring an action for judicial review under ERISA Section 502(a);
- (6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
- (7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and
- (8) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

### **Calculation of Time Periods**

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review or a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

### **Adverse Determination**

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

### **Plan's Failure to Follow Procedures**

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

### **Statute of Limitations for Plan Claims**

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

### **Appointment of Authorized Representative**

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

### **Physical Examinations**

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose illness or injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.



## COORDINATION OF BENEFITS

### **Benefits Subject to This Provision**

This provision applies to all benefits provided under any section of this Plan.

### **Excess Insurance**

If at the time of injury, sickness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

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

- (1) Any primary payer besides the Plan;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third-party;
- (4) Worker's compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

### **Vehicle Limitation**

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

### **Allowable Expenses**

"Allowable expenses" shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

### **Other Plan**

"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

- (1) Group, blanket or franchise insurance coverage;
- (2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
- (3) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;
- (4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
- (5) Coverage under any Health Maintenance Organization (HMO); or
- (6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

### **Application to Benefit Determinations**

The Dental benefits of the Plan will not be available to the extent they are provided to you under any other group plan if the other plan:

- (1) does not include a Coordination of Benefits or non-duplication provision, or
- (2) includes a Coordination of Benefits or non-duplication provision and is the primary plan as compared to this Plan.

### **Order of Benefit Determination**

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

- (1) A plan without a coordinating provision will always be the primary plan;
- (2) The plan covering the person directly rather than as an employee's dependent is primary and the other plans are secondary.
- (3) Active/laid-off or Retirees: The plan which covers a person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
- (4) Dependent children of parents not separated or divorced or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
- (5) Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
  - (a) The plan of the parent with custody pays first;
  - (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
  - (c) The plan of the parent without custody pays next; and
  - (d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

- (6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

### **Right to Receive and Release Necessary Information**

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

### **Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

### **Right of Recovery**

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

### **Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

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

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said

payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

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

- (1) In error;
- (2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- (3) Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
- (4) With respect to an ineligible person;
- (5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or
- (6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

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

### **Medicaid Coverage**

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

### **Coordination of Benefits with Medicaid**

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

### **Coordination of Benefits with Medicare**

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense under the Plan (meaning that the Plan will base its payment upon benefits allowable by Medicare).

In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

- (1) **The Working Aged Rule:** Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a spouse). When you or your spouse become eligible for Medicare due to the attainment of age 65, you or your spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

- (2) **The Working Disabled Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.
- (3) **End-Stage Renal Disease Rule:** Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

### **Medicare and COBRA**

For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

### **Coordination of Benefits with TRICARE**

The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

## **SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT**

### **Payment Condition**

- (1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist and medical payment provisions (collectively "coverage").
- (2) The Covered Person, his or her attorney and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
- (3) In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- (4) If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

### **Subrogation**

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.
- (2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
- (3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- (4) If the Covered Person fails to file a claim or pursue damages against:
  - (a) The responsible party, its insurer or any other source on behalf of that party;
  - (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
  - (c) Any policy of insurance from any insurance company or guarantor of a third party;
  - (d) Workers' compensation or other liability insurance company; or,

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

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

### **Right of Reimbursement**

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- (2) No court costs, experts' fees, attorneys' fees, filing fees or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
- (3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, disease or disability.

### **Excess Insurance**

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

- (1) The responsible party, its insurer or any other source on behalf of that party;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third party;
- (4) Workers' compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

### **Separation of Funds**

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

## **Wrongful Death**

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

## **Obligations**

- (1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
  - (a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights;
  - (b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
  - (c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
  - (d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
  - (e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
  - (f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.
- (2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
- (3) The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Persons' cooperation or adherence to these terms.

## **Offset**

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

## **Minor Status**

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

## **Language Interpretation**

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice.

## **Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.



## DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

**Accident** means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

**Ambulatory Surgical Center** means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

**Calendar Year** means January 1 – December 31.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

**Coinsurance** has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

**Concurrent Review** means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

**Copay** has the same meaning as set forth in the section of this Plan entitled "General Overview of the Plan".

**Cosmetic** means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

**Covered Expense** means:

- (1) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

**Covered Person** means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

**Dentist** means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

**Dentally Necessary** means services or supplies, which are determined by the Plan Administrator to be:

- (1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;
- (2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;
- (3) Within standards of good dental practice within the organized dental community;
- (4) Not primarily for the convenience of the Covered Person, the Covered Person's Dentist or another provider; and
- (5) The most appropriate supply or level of service which can safely be provided.

**Dependent** is a Covered Person, other than the Employee, who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

**Earnings Reduction Agreement** shall mean a written agreement signed by a Participant or the completion of an electronic form provided by the University by which he agrees to reduce his Compensation in order to receive one or more optional benefits under this Plan.

**Eligible Employee** means all Employees meeting the eligibility requirements of Plan. Additionally, the term "Eligible Employee" shall not include any independent contractor; any individual who is leased to the Employer under contract regardless of the hours worked or the length of the contractual period; contract worker; any individual working on special assignment; any individual who has not been designated as of the initial date of the relationship as an employee; any Full-time Student Employee; and any other individual of similar status, treatment, or designation by the University. Further, an Eligible Employee shall not include a "self-employed individual" as defined in Section 401(c) of the Code or a "2-percent shareholder" as defined in Section 1372(b) of the Code. Any subsequent determination or redetermination that such individual is, was, or may have been an employee shall not affect the initial treatment by this Plan of that individual as excluded from employee status and no individual shall be made retroactively eligible. Any such determination or redetermination of such status may only affect the future treatment of that individual as eligible for this Plan and only after the University has designated that individual as eligible.

**Employee** is defined in the "Eligibility for Participation" section of the Plan.

**Employer** means the Plan Sponsor.

**Endodontic Treatment** means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

**Enrollment Date** means the earlier of first day of coverage or, if there is a waiting period, the first day of the eligibility waiting period.

**ERISA** means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.

**Essential Health Benefit** has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as may be further defined by the Secretary of the United States Department of Health and Human Services. Essential Health Benefits includes the following general categories and the items and services covered within such categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); Prescription Drugs; rehabilitative and habilitative services and devices; laboratory service; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Experimental and/or Investigational** means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

- (1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or
- (2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review

Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

- (3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or
- (4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

- (1) The named drug is not specifically excluded under the General Limitations of the Plan; and
- (2) The named drug has been approved by the FDA; and
- (3) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and
- (4) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

**FMLA** means the Family and Medical Leave Act of 1993, as may be amended from time to time.

**Full-Time Employee** means an Employee of the Employer that is regularly scheduled to work 37.5 hours per week (non-exempt) or 40 hours per week (exempt).

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

**Hospital** means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat illnesses or injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

**Illness** means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

**Incurred** means the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

**Injury** means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

**Inpatient** means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

**Late Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

**Lifetime Maximum** means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

**Maintenance Therapy** means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

**Medical Emergency** means medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

**Medically Necessary/Medical Necessity** means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

- (1) "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.
- (2) "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.
- (3) "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

**Medicare** means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

**Non-Participating Provider** means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Orthodontic Treatment** means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

**Participant** shall mean any Eligible Employee who meets the conditions to participate in this Plan.

**Participating Provider** means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

**Part-Time Employee** means and Employee of the Employer that is regularly scheduled to work at least 18.75 hours per week (non-faculty, non-exempt) or 20 hours per week, but no more than 39.976 hours per week (non-faculty, exempt).

**Physician** means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

**Plan** means The Case Western Reserve University DenteMax Dental Plan.

**Plan Administrator** means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

**Plan Sponsor** means Case Western Reserve University or any successor thereto.

**Plan Year** means the period from January 1 - December 31 each year.

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

**Reconstructive Surgery** means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

**Security Standards** mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

**Special Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

**Surgery or Surgical Procedure** means any of the following:

- (1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;
- (2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- (3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

- (4) The induction of artificial pneumothorax and the injection of sclerosing solutions;
- (5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- (6) Obstetrical delivery and dilation and curettage; or
- (7) Biopsy.

**Third Party Administrator** means Meritain Health, Inc., P.O. Box 22033, Lansing, MI 48909-2033.

**Urgent Care Facility** means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

**Usual and Customary Charge (U&C)** means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers.

## PLAN ADMINISTRATION

### Delegation of Responsibility

The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

### Authority to Make Decisions

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

- (1) To administer the Plan in accordance with its terms;
- (2) To determine all questions of eligibility, status and coverage under the Plan;
- (3) To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- (4) To make factual findings;
- (5) To decide disputes which may arise relative to a Covered Person's rights;
- (6) To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- (7) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (8) To appoint and supervise a Third Party Administrator to pay claims;
- (9) To perform all necessary reporting as required by Federal or State law;
- (10) To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
- (11) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- (12) To perform each and every function necessary for or related to the Plan's administration.

### Amendment or Termination of Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.



## MISCELLANEOUS INFORMATION

### **Assignment Of Benefits**

No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

### **Clerical Error**

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to you and/or your Dependents have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

### **Conformity with Applicable Laws**

This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

### **Cost of the Plan**

The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer's general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

### **Interpretation of this Document**

The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

### **No Contract of Employment**

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

### **Release of Information**

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

### **Worker's Compensation**

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from workers' compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- (1) The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- (2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;
- (3) The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- (4) The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

## STATEMENT OF ERISA RIGHTS

As a Covered Person in the Plan, you and your Dependents are entitled to certain rights and protections under ERISA. ERISA provides that you and your eligible Dependents are entitled to:

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

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. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You may experience a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer on request or 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 a pre-existing condition exclusion or limitation for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

### **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Participating Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### **Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

### **Disclosure of Summary Health Information to the Plan Sponsor**

In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

- (1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- (2) Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

### **Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes**

In order that the Plan Sponsor may receive and use PHI for Plan administration purposes, the Plan Sponsor agrees to:

- (1) Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- (2) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- (4) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- (5) Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- (6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- (7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- (8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS") or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- (9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- (10) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
  - (a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions,

access to PHI. You may contact the Plan Sponsor for a list of those persons. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

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

“Plan administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- (1) The Plan documents have been amended to incorporate the above provisions; and
- (2) The Plan Sponsor agrees to comply with such provisions.

**Disclosure of Certain Enrollment Information to the Plan Sponsor**

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

**Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage**

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

**Other Disclosures and Uses of PHI**

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

## HIPAA SECURITY PRACTICES

### **Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions**

To enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- (1) Implement Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- (2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- (3) Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- (4) Report to the Plan any Security Incident of which it becomes aware.

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

### **Health Information Technology for Economic and Clinical Health (HITECH) Act**

The Plan will comply with all applicable requirements of final regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

## GENERAL PLAN INFORMATION

<b>Name of Plan:</b>	Case Western Reserve University Benelect Plan
<b>Plan Sponsor: (Named Fiduciary)</b>	Case Western Reserve University 10900 Euclid Avenue Cleveland, OH 44106 (216) 368-6781
<b>Plan Administrator:</b>	Case Western Reserve University 10900 Euclid Avenue Cleveland, OH 44106 (216) 368-6781
<b>Plan Sponsor EIN:</b>	34-1018992
<b>Plan Year:</b>	January 1 - December 31
<b>Plan Number:</b>	600
<b>Plan Type:</b>	Welfare benefit plan
<b>Plan Funding:</b>	All benefits are paid from the general assets of the Employer.
<b>Contributions:</b>	The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.
<b>Third Party Administrator:</b>	Meritain Health, Inc. P.O. Box 22033 Lansing, MI 48909-2033 (800) 321-4085
<b>COBRA Administrator:</b>	Meritain Health, Inc. P.O. Box 27158 Lansing, MI 48909-7158 Fax No.: (716) 319-5736
<b>Agent for Service of Legal Process:</b>	Case Western Reserve University 10900 Euclid Avenue Cleveland, OH 44106 (216) 368-6781

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.