DENTAL PLAN DOCUMENT

FOR

FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM, INC.

Effective January 1, 2024

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INTRODUCTION

This document is a description of Franciscan Missionaries of Our Lady Health System, Inc. Dental Plan (the "Plan"). No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic dental expenses.

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

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, exclusions, limitations, timeliness of Continuation elections, pre-authorizations, lack of medical necessity, lack of timely filing of Claims or lack of coverage. These provisions are explained in summary fashion in this document and additional information is available from the Plan Administrator at no extra cost.

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

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

This Plan is intended to be operated in compliance with the terms of the Patient Protection and Affordable Care Act requirements, to the extent applicable and any provision not in compliance is deemed modified as necessary to be compliant. This Plan is also intended to be operated in compliance with the terms of the No Surprises Act requirements, to the extent applicable and any provision not in compliance is deemed modified as necessary to be compliant.

The Plan is and has been a church plan as described in Code Section 414(e) and ERISA Section 3(33) since inception and no election has been made applicable law to be subject to ERISA and therefore, the Plan is exempt from Title I and Title IV of ERISA and certain provisions of the Code. The Plan Employer, the Participating Facilities and the Plan Administrator are controlled by and associated with the Roman Catholic Church and take direction from the Roman Catholic Church.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Limitations and Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing Claims and the Claim appeal process.

Coordination of Benefits. Shows the Plan payment orders when a person is covered under more than one plan.

Continuation Coverage Rights. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Covered Person should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit or any other aspect of Plan benefits or requirements.

ELIGIBILITY

General Rules. A person is eligible for Employee coverage if he works in a Benefit Eligible Position, as detailed below.

An Employee hired into a Benefit Eligible Position is eligible to participate in this Plan on the first day of the month after he completes 30 calendar days of employment in a Benefit Eligible Position if the Employee submits a completed enrollment form and complies with the documentation requirements within 30 calendar days of his first day of employment.

Special Rules:

If the Employer acquires the stock or assets of an unrelated company which results in employees of the acquired entity being employed by the Employer in Benefit Eligible Positions, the Benefit Eligible Position employees will be eligible to enroll in the Plan during the month in which the acquisition occurs and coverage will be effective as of the first day of the month following the month containing the acquisition date. The Employer reserves the right to determine the enrollment period in the acquisition month and the enrollment requirements (which include providing dependent verification documentation to askHR@fmolhs.org). This special rule is available only if such action does not cause the Plan to discriminate in favor of highly compensated individuals as to eligibility to participate or benefits provided under the Plan, in accordance with the requirements of IRC Section 105(h).

An Employee who has a status change into a Benefit Eligible Position is eligible to participate in the Plan on the first day of the month after he completes 30 calendar days of employment in a Benefit Eligible Position if he submits a completed enrollment form within 30 calendar days from the date of the change in status.

Benefit Eligible Positions are identified below:

(1) A Full-Time, Active Employee of the Employer who has not elected FPTNB/FTNB Employee status. An Employee is considered to be Full-Time if he or she is normally scheduled to work at least 32 hours per week and is on the regular payroll of the Employer for that work.

(2) A Part-Time, Active Employee of the Employer who has not elected FPTNB Employee status. An Employee is considered to be Part-Time if he or she is normally scheduled to work at least 20 hours per week and is on the regular payroll of the Employer for that work.

Eligible Classes of Dependents. A “Dependent” may include the following individuals, depending upon the coverage elected by the Participant:

(1) A Spouse who is married to a Participant as a result of a legal ceremony which is recognized by the State of Louisiana. For purposes of this Plan, a “Spouse” will not result from a common law marriage.

(2) An Employee's “Child” will be an eligible Dependent until the last day of the month in which he reaches the limiting age of twenty-six (26). For this purpose, the term “Child” includes a natural child, stepchild, adopted child, a child placed with the Employee for adoption, foster children and a child for whom the Participant is required to provide coverage due to a medical child support order that the Plan Administrator determines is a “qualified medical child support order.” An Employee's Child will be an eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Employee or any other person or the death of the biological parent (in the case of an Employee’s stepchild who qualifies as a Child). When the child reaches the applicable limiting age, coverage will end on the last day of the month containing the child's age 26th birthday.

(3) Any unmarried child who is incapable of self-support because of a Handicap (as defined in paragraph (5) below) is entitled to continue coverage under the Plan beyond the month in which the child turned age 26 provided (i) the child is dependent upon the Participant for principal support and maintenance

and (ii) the Participant is entitled to an exemption for federal income tax purposes for the child and (iii) the child was covered under the Plan before the end of the month in which he reached age 26. Proof of the continued existence of such incapacity may be requested by the Plan Administrator from time to time.

(4) A Participant's grandchild who does not qualify for coverage under paragraph (2) above will be considered a "child" and will be able to have coverage until the last day of the month in which the grandchild reaches the limiting age of twenty-six (26) if the Participant (i) has court appointed legal custody or joint legal custody of the grandchild as evidenced by a court order by a court of competent jurisdiction and (ii) has court appointed responsibilities for medical expenses (as evidenced by a court order by a court of competent jurisdiction), and is entitled to an exemption on the Participant's federal income tax return.

(5) For purposes of this definition, "Handicap" means Mental Retardation or any congenital or acquired physical or mental defect or characteristic preventing or restricting an unmarried child of a covered Employee from participating in normal life, or limiting and/or preventing the individual's capacity to work. Such child's Handicap must be certified by a Physician and approved by the Plan Administrator within 30 days after the date the child would otherwise lose Dependent status.

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

If both parents are Employees, their Children will be covered as Dependents of one parent, but not of both.

An Employee cannot have simultaneous coverage as an Active Employee and Dependent.

Eligibility Requirements for Active Employee Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Employer may share the cost of Employee and Dependent coverage under the Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed, and returned with the enrollment application.

The level of Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements.
Once you are hired as a Full-Time Active Employee or a Part-Time Active Employee, you will be provided with information about the Plan. An Employee must enroll for coverage in either the Basic Option or the Buy-Up Option by completing an online application along with submitting required dependent verification documents for enrolled dependents. Paper Enrollment will be provided if online enrollment is not available. **An Employee who elects to work as a FPTNB/FTNB Employee for the year shall not be entitled to enroll under the Plan for the Plan Year or remaining portion of the Plan Year (in the case of a new hire).**

The enrollment and required documents must be completed and received by askHR within 30 calendar days of your date of hire or newly eligible date. It is recommended that you print out a copy of your online elections as this date and time stamp will serve as your electronic signature as well as proof of enrollment in the dental plan. If the enrollment is completed, received and accepted along with required dependent verification documents during your first 30 calendar days of employment, you and each of your eligible dependents who you request to be enrolled in the Plan will become a Covered Member on the first day of the month following 30 days of eligibility if on such date the Covered Member is a Full-time Employee of the Employer and has not elected FPTNB/ FTNB

status. Proof of your relationship with the dependents you enroll will be required. An incomplete online or paper enrollment, or insufficient dependent verification documents may delay your enrollment or the enrollment of your eligible dependents in the Plan.

If your enrollment and all required dependent verification documents are not completed, received by the Plan and accepted within 30 calendar days of your date of hire or newly eligible date, you must wait until the next open enrollment period to join the Plan

TIMELY ENROLLMENT

Timely Enrollment – The enrollment will be "timely" if the online application and the required dependent verification documents are received by askHR within 30 calendar days of the date the person becomes eligible for the coverage; and in the event of a status change, within 30 calendar days of the status change; and in the case of a Special Enrollment, within 30 calendar days of when the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

Grace Period for Deficient Documentation that was Timely Submitted - If the online application and the required dependent verification documents are received by askHR within 30 calendar days of your date of hire, your newly eligible date (because of Special Enrollment or otherwise), or your status change date, as applicable, they are "timely" submitted. If the documentation is provided within the 30 day period, but it is deficient, an Employee will have a seven (7) calendar day grace period from the notification date by askHR to cure insufficient documentation. If the Employee does not return required documentation within the 7-calendar day grace period, the requested enrollment will be denied. If documentation was not submitted within the initial 30 calendar day period, the 7 calendar day grace period will not apply.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his Dependents (including his Spouse) because of other dental insurance or group dental plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the Employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days of the date the coverage ends (or after the Employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact askHR at (833) 482-4547 or askHR@fmolhs.org.

A FPTNB Employee or a FTNB Employee who has made the election under the Cafeteria Plan to receive the Hourly Pay Differential in lieu of participating in the welfare benefit plans offered by the Employer (including this Plan), shall have no Special Enrollment Rights, except as may be required by law.

SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group dental plan or had dental insurance coverage at the time coverage under this Plan was previously offered to the individual. Special Enrollment will also be available to an Employee that declines coverage without having coverage under another plan and subsequently enrolls in other coverage and loses that coverage. However, the Employee must have had an opportunity for initial enrollment or Special Enrollment under this Plan but again chose not to enroll.

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

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(e) For purposes of these rules, a loss of eligibility occurs if:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

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

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

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

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, as of the date of application for coverage;

(b) in the case of loss of coverage, the first day of the month after a completed request for enrollment is received or the date immediately following the loss of the other coverage, whichever is later;

(c) in the case of a Dependent's birth, as of the date of birth; or

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

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Enrollment Pursuant to Termination of Medicaid or CHIP Coverage.

Subject to the conditions set forth below, an Employee who is eligible but not enrolled, or the Dependents of such eligible Employee, if eligible but not enrolled, may enroll in the Plan if either of the following two conditions are satisfied.

(1) Termination of Medicaid or CHIP Coverage. The eligible Employee or Dependent may enroll if the eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

(2) Eligibility for Employment Assistance Under Medicaid or SCHIP. The eligible Employee or Dependent may enroll if the eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under the Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

An eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the eligible Employee or Dependent is determined to be eligible for the premium assistance.

Coverage shall become effective as of the date of application for coverage or the date following the loss of Medicaid coverage.

ENROLLMENT OF DEPENDENT PURSUANT TO A QMCSO

If the Plan Administrator receives a QMCSO, as determined by the Plan Administrator, for an eligible Dependent, the effective date shall be the later of (a) the date of the QMCSO, or (b) thirty (30) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same effective date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan immediately following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for continuation coverage. For a complete explanation of when continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights):

(1) The date the Plan is terminated.

(2) The date the covered Employee's eligible class is eliminated.

(3) The end of the pay period in which the covered Employee is an eligible participant. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

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

(5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect or may immediately terminate coverage.

(6) If an Employee misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty (30) days written notice from the Plan.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.
For leave of absence or layoff only: the date the Employer ends the continuance.

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

Special Rule for Continuation During Periods of Layoff As a Result of Participating in the System-wide Severance Policy: Notwithstanding the foregoing, a person may remain eligible for a limited time if Active, eligible work ceases and the person is laid off under the System-wide Severance Policy. Such laid off employee is entitled to continuation in accordance with the terms of the System-wide Severance policy. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the Severed Participant. When the continuation period for the Severed Participant ends, the Severed Participant shall be entitled to receive continuation coverage rights to the extent there is any remaining period of COBRA continuation coverage. Coverage under the System-wide Severance Policy and COBRA Continuation of Coverage run simultaneously, so that the post termination coverage provided by the Severance Policy shall not extend the COBRA continuation period.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, pre-existing conditions limitations or exclusions and the Waiting Period will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee is rehired within 30 calendar days, the Plan Administrator reserves the right to continue the prior benefit elections. If an individual who elected FPTNB/FTNB status for the Plan Year is rehired within 30 calendar days, his FPTNB/FTNB election will continue and he will not be permitted to make new benefit elections. See the Plan Administrator for application of these rules to your situation. However, if the Employee is returning to work directly from Continuation coverage, this Employee does not have to satisfy the Waiting Period or any pre-existing condition limitation or exclusion.

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

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

(a) The 24 month period beginning on the date on which the person's absence begins; or

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

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

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

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for continuation coverage. For a complete explanation of when continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights):

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

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

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

(4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights.)

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

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Plan may either void coverage for the Dependent for the period of time coverage was in effect or may immediately terminate coverage.

(7) If a Dependent misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty (30) days written notice from the Plan.

If a Covered Person's coverage is terminated as described above, coverage for completion of a dental procedure (except for Orthodontia Services) requiring two or more visits on separate days will be extended for at least 90 days after the Covered Person's termination date in order for the procedure to be finished. The procedure must be started prior to the Covered Person's termination date. The procedure is considered "started" when the teeth are irrevocably altered. For example, for crowns, bridges and dentures, the procedure is started when the teeth are prepared and impressions are taken. For root canals, the procedure is started when the tooth is opened and pulp is removed.

SCHEDULE OF BENEFITS – All benefit payments are limited to Reasonable and Customary.

Reimbursement
Out of Network claims are paid based on 80% of billed charges.

Annual Deductible
For each Covered Person –$50.00. The maximum Annual Deductible per family is three (3) times the individual Deductible.

Annual Maximum
The total amount of benefits that will be paid in a Calendar Year per Covered Person is set forth below:

Basic Dental Option - $1,000
Buy-Up Option - $1,550

Eligible Diagnostic and Preventative services do not count toward the annual maximum. Benefits for Orthodontia do not count to the Annual Maximum but do count for the Orthodontia Annual Maximum.

Coverage Prevention	**Basic Option (In-Network and Out-of Network)**	**Buy-Up Option (In-Network and Out-of Network)**
Type 1 Preventative and Diagnostic Services	100% no deductible	100% no deductible
Type II Basic Restorative Services	50% after deductible	80% after deductible
Type III Major Restorative Services	50% after deductible	50% after deductible
Type IV - Orthodontia	No coverage	50%
Lifetime maximum (for orthodontia services only) applies to dependent children less than 19 years of age	No coverage	$1,500

Type I Preventive & Diagnostic
Diagnostic and Preventive Benefits are not subject to the Annual Maximum.

1. Exams (periodic or comprehensive) are limited to 2 per covered person per calendar year.
2. Prophylaxis, limited to 2 per covered person per calendar year.
3. Topical fluoride treatment for covered dependent children under 16 years of age; limited to 1 time per year.
4. Sealants, limited to permanent first and second molars to age 14 if they are without cavities or restorations on the occlusal surface and do not include repair or replacement of a sealant on any tooth once in 36 months of its application.
5. One bitewing series, limited to 1 per 12 month period.
6. One full mouth or panoramic x-ray, limited to 1 time every 36 months.
7. Space maintainers (fixed unilateral, fixed bilateral, removable unilateral or removable bilateral) that replace prematurely lost teeth of covered dependent children under 16 years of age; maximum of 1 time per space.
8. Diagnostic imaging, including Intraoral and Extraoral x-rays.
9. Emergency evaluation and palliative treatment.

Type II Basic

1. Diagnostic casts are limited to once in any 3 year period.
2. Restorations (primary or permanent, both anterior and posterior). Multiple restorations on one surface will be treated as a single filling. Restorations limited to 1 per surface per 36 months.
3. Pin retention but only in conjunction with an amalgam or composite restoration.
4. Root canals limited to once per tooth per lifetime.
5. Endodontic therapy.
6. Retreat root canal limited to one per 36 months, at least 12 months after initial root canal treatment.
7. Vital pulpotomy and direct or indirect pulp cap
8. Apicoectomy (anterior, bicuspid, molar, or additional root) and retrograde fillings, maximum of 1 time per tooth.
9. Hemisection.
10. Periodontal maintenance, limited to two per calendar year.
11. Periodontal scaling and root planning once per quadrant of the mouth in a 24 month period.
12. Full mouth gross debridement limited to once in a 36 month period.
13. Provisional splinting, but not with respect to crowns or inlays made for the purpose of periodontal splinting.
14. Gingevectomy, maximum of 1 per site per 36 months.
15. Gingival curettage or osseous surgery, maximum of 1 per site per 36 months.
16. Pedical grafts and soft tissue grafts and bone replacement, maximum of 1 per site per 36 months
17. Occlusal adjustment, but only in conjunction with periodontal surgery.
18. Oral surgery limited to once per tooth per lifetime.
19. Extractions (simple and surgical). This service includes local anesthesia and routine post-operative care.
20. Biopsy.
21. Alveoloplasty.
22. Incision and drainage of abscess.
23. Frenulectomy and frenuloplasty
24. Excision of hyperplastic tissue
25. General anesthesia, but only in conjunction with complex oral surgery procedures and subject to review.
26. Removal of both boney impacted and non-boney impacted wisdom teeth.

Type III Major

1. Crowns (resin with metal, porcelain, porcelain with metal, full cast metal, or ¾ cast metal), labial veneers, inlays, and onlays, limited to one per 8 years. Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
2. Post and core (cast and prefabricated for teeth requiring crowns or fixed partial retainers), maximum of 1 per 8 years.
3. Core build-ups, maximum of 1 per 8 years.

4. Complete dentures, immediate dentures, partial dentures, and bridges. Benefits will be based on the corresponding non-cosmetic restoration. Maximum of 1 replacement per 8 year period. Note: At least one tooth must be extracted while coverage is in effect for service to be covered.
5. Re-cement inlays, onlays, crowns, or bridges. 6 months must have passed since initial installation.
6. Repairs of crowns, bridges and removable dentures.
7. Denture adjustments and partial adjustments both upper and lower; six months must have passed since initial placement; maximum of 1 procedure per 6 months.
8. Relines, rebases, and repairs of dentures performed more than 6 months after the initial insertion; limited to one time per 24 months.
9. Adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth.
10. Tissue conditioning (upper and lower), maximum of 1 procedure per arch per 12 months.
11. Charges for dental implants

Type IV Ortho (applies to Buy-Up Plan only)

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth. These services are available for covered Dependent children under the age of 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

EXCLUSIONS AND LIMITATIONS

This section applies to all benefits provided under any section of this Plan/Summary Plan Document. This Plan excludes or limits coverage as described for the following:

Occupational Illness or Injury

Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded.

Government Plan

Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

Unnecessary Services or Supplies

Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

Excess of Reasonable and Customary

That portion of any charge for any services or supplies in excess of the Reasonable and Customary charge, as determined by the Plan Administrator, is excluded.

Injury Due to Act of War

Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Cosmetic or Cosmetic Surgery

Any service or treatment for Cosmetic purposes. The following are always considered to be for Cosmetic purposes:

a. facings on crowns or pontics posterior to the second bicuspid, and

b. personalization of dentures.

However, this exclusion does not apply to services required because of Injuries if:

a. the services are rendered within six months after an Accident, and

b. the services are rendered while the person is covered for these dental benefits.

Other General Exclusions

Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Administrative fees**, interest or penalties.
2. **Appliances, restorations, or procedures**
    a. for altering of vertical dimensions,*
    b. restoring or maintaining occlusion,*
    c. splinting,
    d. correction of attrition or abrasion,
    e. bite registration,
    f. bite analysis, or
    g. treatment of Temporomandibular Joint Syndrome (TMJ).
    * By other than covered orthodontic treatment
3. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.
4. **Claim form**: Completion of a claim form.
5. **Coordination of benefits**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.
6. **Coverage not in force**: Charges incurred while coverage is not in force under the Plan.
7. **Deductible**: Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.
8. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided.
9. **Family member**: Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.
10. **Felonious behavior**: Charges for services received as a result of Injury of Illness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.
11. Any service or supply **not furnished by a dentist**, except a service performed by a dental hygienist working under the supervision of a dentist, and an X-ray order by a dentist.
12. **Not legally required to pay**: Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.
13. **Not listed**: Any items not listed in "Covered Expenses."
14. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Document.
15. **Orthodontic services** or dental care of a congenital or developmental malformation, unless included in the benefits for orthodontic services for Covered Dependent children.
16. **Personal** or convenience items.
17. Charges for **plaque control programs** or instruction in oral hygiene or diet.
18. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Document.
19. **Replacement** of a lost, missing or stolen prosthetic device or other device or appliance.
20. **Replacement** within eight years of its last placement of any

a. prosthetic appliance,
b. crown,
c. inlay or onlay restoration, or
d. fixed bridge.
However, this exclusion does not apply to any such replacement required because of Injury.

21. **Scheduled visit**: Failure to keep a scheduled visit.
22. **Self-inflicted**: Intentionally self-inflicted Injury.
23. **Telephone** conversations with a Physician.
24. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

ORTHODONTIC BENEFIT

Orthodontic Maximum
The total amount of benefits that will be paid over the total course of a lifetime is $1500 per Covered Person or Dependent Child under age 19 if the orthodontic treatment begins on or after January 1, 2011. If the orthodontic treatment begins prior to January 1, 2011, the total amount of benefits that will be paid over the total course of a lifetime would be determined in accordance with the plan terms, limitations and exclusions in the 2010 plan document.

Orthodontia Services
If covered, the Plan will pay benefits for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is insured under the Plan. No payment will be made for orthodontic treatment if the appliances or bands are inserted prior to becoming insured. The Plan considers orthodontic treatment to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

The Plan will pay the Coverage percentage shown in the Schedule of Benefits. The maximum benefit payable to each Covered Person for orthodontic services is shown in the Schedule of Benefits. Those Covered Persons who are eligible for Orthodontia coverage are indicated in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

Exclusions and Limitations
Coverage for services and supplies is not provided for any of the following:

- Replacement of broken appliances;
- Re-treatment of orthodontic cases;
- Changes in treatment necessitated by an accident;
- Maxillofacial surgery (subrogate with medical insurance);
- Miofunctional therapy (TMJ);
- Treatment of cleft palate;
- Treatment of micrognathia;
- Treatment of macroglossia;

Payment of Benefits
Benefits will be pro-rated and paid out over a twenty-four (24) month period or longer based on the treatment plan submitted.

Provider services started after the Covered Person's coverage terminates are not covered. Covered benefits in accordance with the Summary Plan Document in effect at the time coverage terminates will continue for 60 days if the orthodontist is receiving monthly payments or until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist is receiving payments on a quarterly basis. All other provisions of the Summary Plan Document apply to the Orthodontic benefit.

DENTAL BENEFITS

All benefits will be paid after the Covered Person satisfies the Waiting Period and an Annual Deductible up to an Annual Maximum. All benefits are subject to the Exclusions and Limitations set forth in this Summary Plan Document.

The Covered Person may be required to remit payment in full at the time services are rendered. The Covered Person or the provider can then submit a Claim to Claims Administrator for Out-of-Network Benefits under the Plan.

Pre-authorization

Pre-authorization **is strongly recommended** for the following procedure types:

Inlays, Onlays, Crowns

Root canals, Root canal retreatment

Periodontal Surgery

Periodontal scaling and root planning

Full dentures, partial dentures, fixed bridges

Third molar extractions

Complete occlusal adjustments

Implants

Documentation, including diagnostic quality radiographs, periodontal charting and other appropriate visual or written narrative should be sent with proposed treatment. If treatment is done without prior Pre-authorization approval, and documentation is submitted with a Claim, such Claim may not be paid.

Predetermination of Benefits

If the charge for any treatment is expected to exceed $500, it is STRONGLY suggested that a dental treatment plan be submitted to the Plan by Your dentist for review before treatment begins. This process is called predetermination and is separate and different from Pre-authorization. This may be helpful to estimate both the benefits available and your anticipated out of pocket expense. Predetermination is optional and not a requirement for use of benefits

The proposed services will be reviewed and a predetermination of benefits statement will be issued to the Covered Person or the Provider detailing the benefits that will be covered by the Plan. The predetermination is good for 180 calendar days.

Payment will be subject to the Plan benefits (e.g. Annual Maximums), limitations and exclusions in force at the time the Claim is submitted. Predetermination of benefits is also subject to the Alternate Benefit Provision immediately below.

Alternate Benefit Provision

Many dental problems can be resolved in more than one way. If: 1) The Plan determines that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, the Plan may use the less expensive alternative benefit to determine the amount payable under the Plan. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, the Plan may base its benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-participating Provider performs the service.

Services Performed Outside the United States of America

Any claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Service, as defined; (2) be supplied in English; and (3) **use American Dental Association (ADA) codes** or provide a narrative of the services received. The benefit will be based on the Usual and Customary rate for the Group's zip code.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis (0.8-1.0 FTE) or part time basis (.5-.799 FTE). The term "Active Employee" does not include independent contractors, temporary employees, leased employees or contract employees.

Allowable Charge is the allowable amount the Plan pays, less any applicable coinsurance or deductibles. The allowable charge for services from Non-Participating Providers is based on 80% of billed charges.

Annual Deductible means the amount set forth in the Schedule of Benefits which each Covered Person must pay each year before benefits will be paid. The maximum Annual Deductible per family is three (3) times the individual Deductible as set forth in the Schedule of Benefits.

Annual Maximum means the total amount of benefits that will be paid in a year as set forth in the Schedule of Benefits to the Covered Person. Benefits for Orthodontia, Eligible Diagnostic and Preventative Services do not count to the Annual Maximum.

Calendar Year means January 1st through December 31st.

Claim means any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims.

Claims Administrator is Delta Dental Insurance Company, P.O. Box 1809 Alpharetta, GA 30023-1809.

Coinsurance means a specified percentage of the Allowable Charge that you must pay as a condition of the receipt of certain services as provided under the Plan. Specific Coinsurance amounts are listed in the Schedule of Benefits. In some circumstances, the Maximum Allowable Charge will be more than the charges the Provider has billed for the Covered Services. In these cases, you will still be responsible for Coinsurance based on the Allowable Charge.

Covered Service means a procedure listed in the attached Schedule of Benefits. If a procedure is not listed, it will not be covered under the Summary Plan Document. All procedures are subject to the Exclusions and Limitations set forth in this Summary Plan Document.

Covered Person means a person covered under the Plan.

Deductible means the amount a Covered Person must pay toward Covered Services under the Plan before the Plan begins paying for services. This Summary Plan Document lists the Deductible that applies to you.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Franciscan Missionaries of Our Lady Health System and the Participating Facilities listed in the "General Plan Information" section. Heart Hospital of Lafayette, LLC is not a participating facility as of January 1, 2020 notwithstanding the fact that it became a subsidiary of Our Lady of Lourdes Regional Medical Center, Inc. as of January 1, 2020. The Employer for purposes of the ability to amend or terminate the Plan is limited to the Franciscan Missionaries of Our Lady Health System.

Experimental/Investigational means drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, Medicare, and the Dental Director as universally accepted treatment.

FPTNB/ FTNB Employee means a Full-Time Active Employee in a clinical position identified on Exhibit A or Exhibit B of the Cafeteria Plan, who has completed a written election to receive an Hourly Pay Differential in lieu of participating in the welfare benefit plans offered the Employer. Unless a FPTNB/FTNB Employee incurs a Special Enrollment Period under Code Section 9801(f), such FPTNB/FTNB Employee will be ineligible to

participate in the Plan for the Plan Year or in the case of a newly hired employee, for the remaining portion of the Plan Year containing his or her date of hire. Note that a FPTNB Employee can include a Part-Time Active Employee.

Member Service Department means the Claims Administrator's Member Service Department, which includes services for Covered Persons. The number for the Member Service Department is located on Your ID card.

Participant means a Covered Person who is or was an Employee.

Plan means the Franciscan Missionaries of Our Lady Health System, Inc, Dental Plan, which is a benefits plan for certain, Employees of Employer and is described in this document. This Plan document shall also serve as the Summary Plan Document.

Plan Administrator is the Franciscan Missionaries of Our Lady Health System, Inc.

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

Pre-authorization means approval by the Claims Administrator that is required for payment for certain services to be performed. Pre-authorization does not guarantee payment if the Covered Person is not covered at the time the service is provided. Pre-authorization does not guarantee payment at the In-Network benefit level for services rendered by Non-Participating Providers.

Provider means a practitioner of dentistry duly licensed by the State Board of Dental Examiners acting within the scope of his license. Provider does not include: the Covered Person or the Covered Person's Spouse; or the Covered Person or the Covered Person Spouse's child, parent, brother, sister, or a person living with the Covered Person.

Prudent Layperson means a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A Prudent Layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

Qualified Medical Child Support Order ("QMCSO") means an order from a court of competent jurisdiction or a state agency stating that the Eligible Person is responsible for providing coverage under the Plan. You should contact your Plan Administrator for answers to any questions you have with respect to a QMCSO.

Schedule of Benefits means a schedule of covered benefits, fully discussed in this Summary Plan Document, which delineates the Covered Person's Coinsurance, Deductibles, annual maximums, and other benefit limitations. The Schedule of Benefits is included with this Summary Plan Document/Plan.

Summary Plan Document means this document, which serves as the Plan document and the Summary Plan Document.

Utilization Management Policies means the evaluation of the appropriateness, medical need and efficiency of the proposed dental care service procedures. Such procedures include Pre-authorization, pre-determination and alternate benefit provisions.

You/Your means a Covered Person covered under this Summary Plan Document

CLAIM PROVISIONS

HOW TO SUBMIT A CLAIM

A dental provider or other authorized representative may file a Claim or an appeal on your behalf. All references in this section to "Covered Person" will include an authorized representative. Claims Administrator may require proof that a person is your authorized representative.

Notice of Claim - Written notice must be given within 60 days after treatment or as soon as reasonably possible. Notice should include the Covered Person's name, address and group number. Claims Administrator may not invalidate or reduce a Claim if it is shown that it was not reasonably possible to give notice within 60 days and notice was given as soon as was reasonably possible.

Claim Forms - Claims Administrator will provide Claim forms for filing Proof of Loss to each claimant or to the Employee for delivery to the claimant. If Claims Administrator does not provide the Claim forms within 15 days after Notice of Claim is received, the claimant is considered to have complied with the requirements of the Plan as to Proof of Loss if the claimant submits within the time fixed by the Plan for filing proof of loss, written proof of the occurrence, character, and extent of the loss for which the Claim is made.

Claims for Benefits must be filed on a standard Claim Form which you or your Dentist may obtain from:

Delta Dental Insurance Company
P.O. Box #1809
Alpharetta, Georgia 30023
(800) 521-2651
deltadentalins.com

Proof of Loss - Written proof, satisfactory to the Plan, must be given to the Plan within 60 days after the date of loss. If that is not reasonably possible, the Plan will not deny or reduce any Claim if proof is furnished as soon as reasonably possible except in the absence of legal capacity, not later than 1 year from the time proof is otherwise required.

Time of Payment of Claims - Benefits payable under the Plan for any loss will be paid not more than 30 days after written receipt of Proof of Loss. The Plan reserves the right to request x-rays, narratives and other diagnostic information, as the Plan sees fit, to determine benefits.

How To Submit Claims: - Claims submitted to Claims Administrator must identify the treatment rendered using the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. The Plan reserves the right to request x-rays, narratives and other diagnostic information, as the Plan sees fit to determine benefits.

Overpayment Recovery: Claims Administrator reserves the right to deduct from any benefits properly payable under the Plan the amount of any payment that has been made:

1. in error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under the Plan within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits are recoverable under this Plan or any other plan or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Plan made by a Covered Person if Claim payments previously were made with respect to a Covered Person.

Payment of Claims - All benefits will be paid to the Covered Person unless assigned by the Covered Person to the Provider. Only one Claim amount will be paid for each Covered Service. Any benefits unpaid at the time of the Covered Person's death will be paid in one lump sum to the first surviving class of the following classes of persons:

a) wife or husband;

b) children;

c) mother and father;

d) sisters and brothers.

If there is no surviving member of any of the above classes, the benefits will be paid to the Covered Person's estate.

Legal Actions - No legal action for reimbursement of a claim for payment for services may be initiated prior to the exhaustion of the Plan's appeals procedures. No legal action for reimbursement of a claim for payment for services may be initiated more than three (3) years after the expiration of the date of service of the Claim at issue or if earlier, twelve months after the final review/appeal decision by the Plan Administrator/Claims Administrator has been rendered.

CLAIMS REVIEW PROCEDURE

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

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Claims Administrator.

Informal Inquiry Process

Most complaints begin as an informal inquiry. Covered Persons should direct informal inquiries to the Plan via the Plan Customer Services Department Monday through Friday from 8:00 a.m. to 5:00 p.m. at the telephone number listed below:

Toll-free: 1-800-521-2651

A customer service associate will review, research and resolve the inquiry. The Covered Person will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Covered Person, the Covered Person will be advised of his/her right to request a formal complaint. Covered Persons also have the right to bypass the informal inquiry procedures and immediately file a formal complaint.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician or Provider, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A physician or Provider with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician or Provider, an individual acting on behalf of the Plan applying the judgment of a Prudent Layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Claims Administrator and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

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

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

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

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	60 days

Notice to claimant of adverse benefit determinations

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

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

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

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

(4) A description of the Plan's review procedures and the time limits applicable to such procedures.

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

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

(7) If the adverse benefit determination is based on the medical necessity or Experimental/Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

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

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

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

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

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

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

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

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by the Claims Administrator who is neither the individual who made the adverse determination nor a subordinate of that individual.

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

Review of appeals shall be concluded within the following time frames:

- Urgent Care Appeals – Within thirty-six (36) hours after receipt of the appeal. The Claims Administrator will notify the Covered Person and/or the authorized representative verbally and will provide written notice within thirty-six (36) hours after receipt of the appeal.
- Pre-service Appeals - within fifteen (15) days of the request for appeal.
- Post-service Appeals - within thirty (30) days of the request for appeal.

The Claims Administrator will advise the Covered Person or authorized representative of the determination in writing giving the reason for the decision.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) will apply when a Covered Person is covered for dental benefits under more than one Plan. For purposes of this section, “Plan” is defined below under Plans Considered for COB.

If this COB provision applies, the Order of Benefit Determination Rules below should be looked at first. Those rules determine whether this Plan is a Primary Plan or a Secondary Plan. A “Primary Plan” means the Plan that pays benefits or provides services first under the rules. A “Secondary Plan” is any Plan that is not a Primary Plan. When there are more than two Plans covering the Covered Person, this Plan may be: a Primary Plan as to one or more other Plans; and a Secondary Plan as to a different Plan or Plans.

If this Plan is:

1. a Primary Plan, COB will not apply and benefits will not be reduced; or

2. a Secondary Plan, COB will apply, and benefits may be reduced so that the total payment from all Plans will not exceed 100% of total Allowable Expenses. This reduction is described under Effect on Benefits below.

Plans Considered for COB

“Plan” is any of the following that provides benefits or services for or because of dental care or treatment:

1. group; blanket or franchise insurance; or other group type coverage, whether insured or uninsured;

2. union welfare plans; employer organization plans; or labor management trusteed plans; or

3. coverage under a governmental plan; or coverage required or provided by law. This does not include benefits payable under any state plan under:

    a. Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or
    b. any plan when, by law, its benefits are in excess of those of any private insurance plan or other non-governmental plan.

Each contract or other arrangement for coverage under 1 through 3 is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Plan" will not include:

1. individual or family policies; or individual or family subscriber contracts; this includes: prepayment; service; group practice; or individual practice coverage;

2. school accident type coverage; or

3. guaranteed renewable individual intensive care or specified disease policies.

Order of Benefit Determination Rules

General

When there is a basis for a Claim under this Plan and another Plan, this Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and

2. both those rules and this Plan's COB Rules require that this Plan's benefits be determined before those of the other Plan.

Rules

This section determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the Plan which covers the individual as an employee, covered person or subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the individual as a Dependent. Note that the benefits of a benefit plan which covers a person as a dependent spouse are determined before those of a plan which covers a person as a dependent child.

2. Dependent Child/Parents not Divorced. Except as stated in Rule 3., when this Plan and another Plan cover the same child as a Dependent of different individuals, called "parents":

    a. the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year;
    b. but, if both parents have the same birthday, the benefits of the Plan that covered one parent longer are determined before those of the Plan that covered the other parent for a shorter period of time;
    c. however, if the other Plan:

        i. does not have this "birthday rule"; but
        ii. 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.

3. Dependent Child/Parents Divorced. If two or more Plans cover a child as a Dependent child of divorced parents, benefits for the child are determined in this order:

a. first, the Plan of the parent with custody of the child;
b. then, the Plan of the spouse of the parent with the custody of the child; and
c. finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state:

a. that one of the parents is responsible for the health care expense of the child; and
b. the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms,

the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any:

a. Claim Determination Period; or
b. Plan Year;

during which any benefits are actually paid or provided before the entity has the actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers the individual as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers the individual as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule 4. is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, person or subscriber longer are determined before those of the Plan which covered the employee, person or subscriber for the shorter term.

Effect on Benefits

COB applies to this Plan when, in accordance with the Order of Benefit Determination Rules, this Plan is a Secondary Plan as to one or more other Plans. In that event, the benefits of this Plan may be reduced under this COB provision. Such other Plan or Plans are referred to as "the other Plans" immediately below.

Reduction in This Plan's Benefits

The benefits of this Plan will be reduced when the sum of:

1. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and

2. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made;

exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

"Allowable Expense" means an expense that is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means the year defined in the Schedule of Benefits. However, it does not include any part of a year during which an individual has no coverage under this Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. Claims Administrator has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. Claims Administrator need not tell, or get the consent of, any individual to do this. Each Covered Person claiming benefits under the Plan must give Plan Administrator any facts it needs to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan. Claims Administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Claims Administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of:

1. the individuals it has paid or for whom it has paid;

2. the insurance companies; or

3. the other organizations.

The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

CONTINUATION COVERAGE

What is continuation coverage? Continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-continuation beneficiaries). Because the Plan sponsor is a church entity, the Plan is a church plan and is exempt from the federal tax rules. It operates to provide continuation coverage in a manner which is very similar to the requirements of the federal tax law.

Because the Plan was amended effective January 1, 2022 to add a second benefit option, the Participants on COBRA will be able to elect the benefit option which will apply to them after December 31, 2021 for the duration of their COBRA period. In the absence of a timely election, they will participate in the Buy-Up Option as of January 1, 2022 for the duration of their COBRA period.

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

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

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of continuation coverage, and any individual who is covered by the Plan as an alternate recipient under

a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

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

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

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

(1) The death of a covered Employee.

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

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

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

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

Notwithstanding the foregoing, an Employee who loses his job and is provided with severance benefits in accordance with the System-wide Severance Policy shall have the COBRA continuation period measured from the date his employment ends. The continuation coverage provided by the System-wide Severance Policy shall run concurrently with COBRA and shall not extend the period of the COBRA continuation coverage.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect Continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect Continuation coverage. If coverage is not elected within the 60 day period, all rights to elect Continuation coverage are forfeited.

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

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

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the Employer, or

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

IMPORTANT:

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

NOTICE PROCEDURES:

Any notice that You provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver Your notice to the person, department or firm listed below, at the following address:

Franciscan Missionaries of Our Lady Health System, Inc.

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

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

If the Qualifying Event is a **divorce**, Your notice must include **a copy of the divorce decree.**
Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

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

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

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

coverage (but only after any applicable pre-existing condition exclusions or limitations of that other plan have been exhausted or satisfied).

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

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

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

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

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

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional information about Continuation Coverage is available from the COBRA Administrator:

Voya Financial
P.O. BOX 4929
Manchester, NH 03105
(833) 232-4673

HIPAA PRIVACY REQUIREMENTS

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards. These provisions apply only to the extent required by the federal law.

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Franciscan Missionaries of Our Lady Health System, Inc.'s workforce are designated as authorized to receive Protected Health Information from Franciscan Missionaries of Our Lady Health System, Inc. Dental Plan ("the Plan") in order to perform their duties with respect to the Plan:

Appropriate Personnel of Human Resources and Appropriate Personnel of Accounting

HIPAA SECURITY REQUIREMENTS

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents reflect certain obligations required of the Employer as set forth below:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: Franciscan Missionaries of Our Lady Health System, Inc. Dental Plan

PLAN NUMBER: S-2559

TAX ID NUMBER: 72-1028323

PLAN EFFECTIVE DATE: January 1, 2024

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION: Franciscan Missionaries of Our Lady Health System, Inc.

PLAN ADMINISTRATOR: Franciscan Missionaries of Our Lady Health System, Inc.

NAMED FIDUCIARY: The Employer, Franciscan Missionaries of Our Lady Health System, Inc.

PARTICIPATING FACILITIES

- Franciscan Missionaries of Our Lady, North American Province, Inc.
- Franciscan Missionaries of Our Lady Health System, Inc.
- The Franciscan Missionaries of Our Lady University

AGENT FOR SERVICE OF LEGAL PROCESS: Plan Administrator
Franciscan Missionaries of Our Lady Health System, Inc.

CLAIMS ADMINISTRATOR:
Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

BY THIS AGREEMENT, the Franciscan Missionaries of Our Lady Health System, Inc. Dental Plan is hereby adopted as set forth herein.

IN WITNESS WHEREOF, this instrument is executed for Franciscan Missionaries of Our Lady Health System, Inc. on or as of the day and year first below written.

Franciscan Missionaries of Our Lady Health System, Inc.

By Michael E. Gleason
Michael E. Gleason (Dec 20, 2023 07:35 CST)
Michael E. Gleason, Executive Vice President and Chief Financial Officer

Date Dec 20, 2023

Witness Debra Terrell
Debra Terrell (Dec 20, 2023 10:01 CST)

Date Dec 20, 2023

34368F

FINAL 12.18.2023 2024 FMOLHS Dental Plan-v2_LD_

Final Audit Report 2023-12-20

Created:	2023-12-20
By:	Laura Dalferes (laura.dalferes@fmolhs.org)
Status:	Signed
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Signer michael.gleason@fmolhs.org entered name at signing as Michael E. Gleason
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Signer debra.terrell@fmolhs.org entered name at signing as Debra Terrell
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Document e-signed by Debra Terrell (debra.terrell@fmolhs.org)
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