



OKLAHOMA LUMBERMEN'S ASSOCIATION

DENTAL PLAN

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

The Benefits and coverages described herein are provided through a Trust Fund, The Health Plan Trust for the Members of the Oklahoma Lumbermen's Association, established by a group of employers, members of the Oklahoma Lumbermen's Association. The Trust Fund is not subject to any insurance guaranty association. Other related financial information is available from your employer or from the Oklahoma Lumbermen's Association. Excess insurance is provided by a licensed insurance company to cover certain claims which exceed certain amounts. This is the only source of funding for these benefits and coverages. The benefits and coverage described herein are funded by contributions from employers and employees who are eligible for coverage.

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INTRODUCTION

This document is a description of the Oklahoma Lumbermen's Association Dental Plan (the Plan). **No oral interpretations can change the Plan.** The Plan described provides benefits for Covered Persons to help offset certain 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 Plan Sponsor fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

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

Terms noted with Capitalization have specific meaning in the plan and are identified in the Section "Defined Terms."

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, even if the expenses were incurred as a result of an Injury or Illness that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for Covered Persons and is divided into the following parts:

Employer Participation Provisions and Contributions. Describes the requirements that an Employer must meet to participate in the Plan, and how the Plan is funded.

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

Dental Benefits. Explains when the dental benefit applies and the types of charges covered.

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

Plan Exclusions and Limitations. Describes what charges are not covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

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

Subrogation, Right of Reimbursement, and Third Party Recovery Provisions. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries or illness sustained. Describes the Covered Persons responsibilities to establish a valid claim when a third party may be liable for covered expenses.

COBRA Continuation Options. Explains when a person's coverage under a plan ceases and the continuation options which may be available, if applicable. *Applicable only to Qualified Beneficiaries whose eligibility arises from the Employee's employment by an Employer subject to COBRA. An Employer exempt from COBRA and not subject to these provisions is one that normally employed fewer than 20 employees during the preceding calendar year, or as otherwise determined to be exempt.*

Privacy Provisions. Summarizes protection of Covered Persons' health information, rights under federal law and how they may control the use of their information.

Responsibilities for Plan Administration. Explains how the Plan is operated and managed by the Plan Sponsor.

ERISA Disclosures and Information. Discloses important plan information as required by ERISA.

ERISA Rights Statement. Discloses Covered Persons' rights under ERISA.

EMPLOYER PARTICIPATION PROVISIONS AND CONTRIBUTIONS

Eligible Employer. This Plan is operated and maintained for benefit of Members of the Oklahoma Lumbermen's Association, their Employees and eligible Dependents. An Eligible Member's Employees and their eligible dependents shall be eligible subject to the provisions of the section **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS** and **only** if their Eligible Participating Employer has complied with requirements of participation in the Plan and the provisions of this Section.

An Eligible Employer must meet the following requirements:

- 1) Be a Member of the Oklahoma Lumbermen's Association;
- 2) Have executed the required Employer Application and Agreement for participation in the Plan;
- 3) Have paid all contributions as required herein; and
- 4) Complies with all Plan rules regarding employee eligibility and the Plan's required percentage of Eligible Employee participation as described in the Employer Application and Agreement.

Contributions. Each Participating Employer must remit to the Plan the required contributions. The sources of these contributions are the Employer and/or the participating Employees, as determined by the Employer's policies. In the event that an Employer fails to remit contributions in a timely manner, the fact that a contribution has been collected by the Employer from an Employee is not binding on the Plan.

Contributions must be paid on or before the first day of the period for which they are due. A 31-day grace period will be granted. If payment is not made during the 31-day grace period the Employer's participation will terminate and coverage will be cancelled for all participants (including dependents) of the Employer. If any claim payments are made during a period of lapse, the Plan shall make every reasonable attempt to recover such payments from the Employer. An Employer will not be considered for reinstatement, nor shall any records or reports be released until such amounts are recovered in full by the Plan.

The contributions required will be determined by the Plan Administrator at its discretion. Contributions may be modified and adjusted upon one calendar month's notice to accommodate any changes in Plan benefits, increased benefit expense, changes in administrative expenses or for the maintenance of reserves. Contributions will be determined in a manner consistent with applicable laws and regulations. The Plan Administrator shall have the ability to surcharge Participating Employers and to maintain, increase, reduce or terminate such surcharges as it deems appropriate.

In the event that contribution levels will be changed Employers will be provided with a minimum of one calendar month notice. It is the responsibility of the Participating Employer to notify its participating employees of any change that will affect employee withholding or contribution amounts. Employee contributions, if any, are the sole discretion of the participating Employer and may be subject to applicable law.

Cancellation by a Participating Employer must be received in writing by the Plan Administrator prior to the beginning of the final calendar month of coverage. Cancellations or terminations are only allowed to be effective the **last day** of the final month of coverage. Partial month termination requests and/or contribution refund requests will not be honored.

The Plan may from time to time find it necessary to request certain information, reports, lists, forms, applications or other information including employee and/or employer information from any Participating Employer. It shall be the Participating Employer's responsibility to provide such requested information in a timely manner. Failure of any Participating Employer to supply any such information as requested may result in termination or non-renewal of coverage.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY for PLAN Participation

Eligible Classes of Employees.

Any **Active Full-Time Employee** (as determined by the Participating Employer and described in the Employer Application and Agreement, but in no case less the required minimum of the Plan) of any Participating Employer shall be eligible for coverage upon completion of the Employer designated waiting period. This Plan does not cover part-time employees or retirees. The required minimum of the Plan for full time employment is an average of not less than 30 hours per week for the most recent period as established by the Employer as a waiting period.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- (1) Is a Full-Time, Active Employee of the Participating Employer. An Employee shall be considered to be Full-Time if he or she meets his/her Employer's policy for full time employment (subject to the minimum requirement of the Plan.) Owners, Officers, Directors and their family members are required to meet the requirements of the Employer for full time employment requirement to establish eligibility.
- (2) Completes a Waiting Period, if required by the Employer.

Eligible Classes of Dependents. A Dependent is any of the following:

- (1) (a) A Spouse.
(b) A Child to age 25
- (2) A Child of a Participant who is an alternate recipient under a Qualified Medical Child Support Order. If not already enrolled, the Participant must also enroll in the Plan. The Child has a right to coverage with no Pre-Existing Conditions limitation.

- (3) A Child who is: (a) Totally Disabled; (b) not capable of maintaining employment due to mental retardation or physical handicap; (c) dependent upon a Covered Person for support and maintenance; (d) not married; and, (e) covered under the Plan when an age limit is reached.

At reasonable intervals during the 2 years after Dependent reaches an age limit, the Plan Administrator may require subsequent proof of Total Disability and dependency. After this 2-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, for the existence of incapacity.

The following are excluded as Dependents.

- (1) Other persons that live in the Covered Person's home, but not eligible. A child whose parent(s) reside with the Employee or whose parent(s) are covered as dependents is not eligible.
- (2) A divorced former Spouse.
- (3) A person on active duty in military service of any country.
- (4) Or any person who is covered under the Plan as an Employee.

Eligibility Requirements for Dependent Coverage. A Covered Person's family member becomes eligible for coverage on the first day that the Covered Person is eligible for coverage and the family member satisfies the requirements for coverage. The Plan Administrator may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent. The Covered Person is solely responsible to notify the Plan Administrator of changes in the status of a family member that may affect dependent coverage.

If a person covered by the Plan changes status from Covered Person to Dependent or Dependent to Covered Person, and the person is covered continuously under the Plan before, during and after the status change, credit will be given for deductibles and out-of-pocket payments. All amounts applied to Lifetime maximums under any Option under the Plan will be applied to the person.

If both husband and wife are Covered Persons, their Children will be covered as Dependents of the husband or wife, but not both.

FUNDING

Contributions to the Plan.

The Employer is responsible for paying all contributions for coverage under this Plan. These contributions may be shared with covered Employees at the discretion of the Employer. The required Employee participation for making contributions is determined by each Eligible Employer and is not governed by this Plan.

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

ENROLLMENT

If an Employee does not enroll when first eligible, the Employee may only enroll at a later time according to the special enrollment period provisions or as a late enrollee during open enrollment. Please read this section carefully.

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is also required to enroll for Dependent coverage, if Dependent coverage is desired.

Enrollment Requirements for Newborn Children - A newborn child of a covered Employee who has Full Family or dependent child coverage on the date of birth is automatically enrolled in this Plan, subject to provision of required enrollment information. Eligible claims will be applied to the coverage of the newborn child.

Any other newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section. There will be no payment from the Plan for the newborn child's claims if the employee does not elect to cover such newborn within 31 days of the date of birth.

TIMELY ENROLLMENT

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

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

SPECIAL ENROLLMENT PERIODS

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

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

- (1) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (2) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other enforce dental coverage was the reason for declining enrollment.
- (3) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

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

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

A Special Enrollment Period will begin for a Child of a Participant that is an alternate recipient under a Qualified Medical Child Support Order. This Special Enrollment Period will also begin for the applicable Participant if that Participant was not enrolled in the Plan. The Child's eligibility under the Plan is contingent upon the Participant's eligibility under the Plan. The Employer and the Plan must be notified of the Qualified Medical Child Support Order within 60 days of its issuance for this Special Enrollment Period to be available. The Special Enrollment Period will expire 31 days after notification to the Employer or the Plan.

Dependent beneficiaries.

If 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**

A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth if the employee elects to cover the newborn; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

OPEN ENROLLMENT

This Plan has an annual open enrollment opportunity during the month of December. If the employee did not elect to enroll when first eligible or at the time of a Special Enrollment event he or she may enroll during the open enrollment period as a Late Enrollee. As such the employee and any eligible dependents will be subject to all Pre-existing Conditions provisions and exclusions.

Elections made during the open enrollment period will become effective January 1 of the following year.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of 12:01 a.m. on the first day of the month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement, including any waiting period established by the Employer.
- (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 (except for health status reasons) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the 1st day of the following month that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met. If a newly enrolled Full-Time Student, the Effective Date will be the first day of the first month of the current academic period as defined by an accredited secondary school, college, vocational school or university.

TERMINATION OF COVERAGE

When coverage under the Plan stops, Covered Persons will receive a certificate that will show the period of coverage under the Plan. Please contact the Plan Administrator for further details.

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

- (1) **Plan Discontinuance.** Coverage terminates for all Covered Persons on the date the Plan is terminated.
- (2) **Termination of Employment.** If an Employee terminates or is terminated from employment, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when employment terminated.
- (3) **Loss of Employee Eligibility.** If an Employee loses eligible status as defined, coverage ceases for the affected Employee and any Dependents. Coverage ceases on the last day of the month when eligibility was lost.
- (4) **Military Duty.** If a Covered Person enters the armed forces of any country as a full-time member where active duty is to exceed thirty (30) days, coverage ceases for the Covered Person and all persons covered under that person. Coverage ceases on the last day of the month when military duty began.
- (5) **Non payment of Contribution.** The last day of the month for which the Employer makes the required contributions for coverage.
- (6) **Employer Termination.** When the Employer coverage terminates as described in the Employer Participation Provisions & Contributions section of the Plan.

- (7) **Death.** Coverage terminates on the date of death of the Covered Person.

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 COBRA continuation-coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) **Loss of Dependent Status for Child.** Coverage for a Child terminates on the earliest of any of the following:
- (a) The date the Plan or Dependent coverage under the Plan is terminated;
 - (b) The date that the Employee's coverage under the Plan terminated for any reason other than death;
 - (c) On the date which a Dependent child ceases to be a Dependent as defined by the Plan;
 - (d) The date Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days;
 - (e) The last day of the month when the Child becomes age 26;
 - (f) The Last day of the month following the month that the Employee's coverage under the Plan terminated due to death; upon request and payment of any required contributions, dependent coverage may be extended to the end of the month following the month the employee's termination by death.
- (2) **Loss of Dependent Status for Spouse.** Coverage for a Spouse terminates on the date of the following:
- (a) The date the Plan or Dependent coverage under the Plan is terminated;
 - (b) The date that the Employee's coverage under the Plan terminated for any reason other than death;
 - (c) The date Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days;
 - (d) The last day of the month when a legal separation was granted;
 - (e) The last day of the month when a divorce decree was granted;
 - (f) The last day of the month when an annulment was granted.
 - (g) The last day of the month following the month that the Employee's coverage under the Plan terminated due to death;

Continuation During Periods of Employer-Certified Disability. A person may remain eligible for a limited time if Active, full-time work ceases due to disability. This continuance will end as determined by the Employer's policy, but in no case, no later than 12:01 a.m. on the first day of the month immediately following the date six months after the date of disability.

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

Continuation During Family and Medical Leave. Applicable to Employers subject to the Family and Medical Leave Act only. 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 and other Waiting Periods 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 who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements except for:

- (1) an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or Pre- Existing Conditions provision;
- (2) an Employee resuming full-time employment no later than 12 months from the commencement of a lay-off or reduction in hours, provided such Employee was a Covered Person in the Plan on the date of the lay-off or reduction in hours. The effective date of such coverage will be the first of the month following the date of rehire; or
- (3) an Employee returning from a Military Leave as outlined below.

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 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 or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for

DENTAL BENEFITS

This section applies only for members who are enrolled and eligible for dental coverage and for charges that are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Summary Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Summary Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid for a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Summary Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Summary Schedule of Benefits.

COORDINATION WITH MEDICAL BENEFITS

In the event that charges for a service are covered under the Medical and Dental Benefit provisions of the Plan, the Plan will adjudicate the charges first under the Dental Benefits then under the Medical Benefits, unless otherwise indicated in the Medical Benefits section.

LATE ENTRANTS

During the first twelve months that an individual who enrolled as a Late Entrant is covered such Covered Person will only be eligible for Preventative Type I services or services required as the result of a dental Injury. A Late Entrant is someone who does not enroll within 31 days of the date they are first eligible.

DENTAL CHARGES

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

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

SUMMARY SCHEDULE OF BENEFITS

Maximum Benefit Amount	\$1,500 per person, per Calendar Year
Deductible per Calendar Year (waived for Class I Services)	\$100 per person / \$300 per Family Unit
Percentages of reimbursement	Class I Services (Preventative) – 80% Class II Services (Basic) – 80% Class III Services (Major) – 50%
Orthodontia - \$1,000 Lifetime Limit	Orthodontia – 50%

COVERED DENTAL SERVICES

**Class I Services:
Preventive and Diagnostic Dental Procedures**

The limits on Class I Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- 1) Routine oral exams, prophylaxis and bite wing x-rays. This includes the cleaning and scaling of teeth. Limit of two exams per Covered Person every Calendar Year.
- 2) One full mouth series or panoramic x-ray every 36 months.
- 3) Fluoride treatments for covered Dependent children under age 19 limited to two per Calendar Year.
- 4) Space maintainers.
- 5) Sealants for Dependent children under age 19.

**Class II Services:
Basic Dental Procedures**

- 1) Dental exams or x-rays not included in Class I.
- 2) Oral surgery, excluding procedures which are payable under Class III or any medical expense benefit of the Plan.
- 3) Periodontal Services (gum treatments).
- 4) Endodontic treatment (pulp infection and root canal therapy).
- 5) Extractions. This service includes local anesthesia.
- 6) Fillings, other than gold.
- 7) Local and general anesthetics, upon demonstration of Medical Necessity, for oral surgery.

**Class III Services:
Major Dental Procedures**

- 1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- 2) Installation of crowns.
- 3) Installing precision attachments for removable dentures.
- 4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation.
- 5) Addition of clasp or rest to existing partial removable dentures.
- 6) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.
- 7) Recementing bridges, crowns or inlays.
- 8) Repair of crowns, bridgework and removable dentures.
- 9) Rebasement or relining of removable dentures.
- 10) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.
 - (b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
 - (c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

Orthodontic Treatment

Benefits for orthodontic services are limited to treatment of malocclusion or malposition of the teeth, subject to the limitations shown in the Summary Schedule of Benefits.

- (1) Exams, consultations and molds
- (2) Application of appliances
- (3) Cephalometric x-rays
- (4) Periodic examinations, installations and adjustments
- (5) Repairs to appliances

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

DEFINED TERMS

The following terms have special meanings. When used in the Plan, they will be capitalized.

Active Employee. An Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis. An Employee who does not meet this definition solely on the basis of health status will be considered an Active Employee.

Association is the Oklahoma Lumbermen's Association.

Calendar Year. January 1 through December 31 the same year.

Child (Children) The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Stepchildren who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of twenty six (26) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

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

Covered Persons. Employees or Dependent that are covered under the Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent Those persons specified in Eligibility, Funding, Effective Date and Termination Provisions section are eligible for coverage.

Eligible Employer is an employer member of the Association as described in the Section "EMPLOYER PARTICIPATION PROVISIONS & CONTRIBUTIONS."

Employee means a person who is an Active Employee (Full-time) of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is an Eligible Employer who has made application to the Plan Administrator and has been accepted into the Plan.

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

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Filing Deadline. One year from the date the service is incurred.

Illness. A bodily disorder, disease, physical Sickness or Mental Disorder. Illness includes Pregnancy, childbirth or miscarriage. Illness does not include genetically predisposed diseases, disorders or conditions prior to onset of the disease, disorder or condition.

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

Legal Guardian. A person recognized by a court of law as having the duty of taking care of a minor and managing the minor's property and rights.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Lifetime benefits terminate when coverage under this Plan terminates.

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

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

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

Medicare. The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member. Any person who is accorded membership status, of any class, in the Association.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), and for the purpose of this document, Doctor of Optometry (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Physiotherapist, Psychologist (Ph.D.), Speech Language Pathologist, Physician's Assistant (P.A.) and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan. The Oklahoma Lumbermen's Association Dental Plan that includes this written document, the enrollment form and any attached amendments.

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.

A **Qualified Medical Child Support Order** is any judgment, decree or order (including approval of a settlement agreement) which provides for child support with respect to a Child of a Participant or provides for health benefit coverage to such a Child, is made pursuant to a state domestic relations law (including a community property law, and related to benefits under the Plan, or is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act with respect to the Plan) if such judgment, decree or order is issued by a court of competent jurisdiction or is issued through an administrative process established under state law and has the force and effect of law under applicable state law, and which creates or recognizes the existence of an Alternate Recipient's right to or assigns to an Alternate Recipient the right to receive benefits for which a Participant is eligible under the Plan.

Sickness. A person's Illness, disease or Pregnancy.

Spouse The term "Spouse" shall mean the person of the opposite gender recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

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

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

The Plan calculates benefits based on the actual charge billed if it is lesser than the Usual and Reasonable Charge.

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

Waiting Period. The period of time that must pass after the Enrollment Date before coverage in the Plan becomes effective. This period of time is defined by the Employer Participation Agreement.

PLAN EXCLUSIONS AND LIMITATIONS

For all dental benefits listed in this section, the following are not covered.

Maximum Amount. The maximum amount payable by the Plan for any covered treatment is the least expensive alternate treatment that is customarily employed nationwide to treat Sickness or Injury, and recognized by the dental profession to be appropriate.

Benefit Order. If dental services and supplies are covered under medical benefits, then those provisions, limitations and exclusions apply, and this Plan will be secondary with benefits allowed in accordance with the section, Coordination of Benefits.

Exclusions. The Plan will not pay benefits for charges in connection with the following:

- 1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records; mailing charges and sales taxes.
- 2) **Broken appointments.** Charges for broken or missed dental appointments.
- 3) **Cosmetic care.** Charges incurred as a result of any surgery, procedure or treatment to enhance or change the external appearance, or complications of such surgery, procedure or treatment; unless such treatment is rendered to correct a condition resulting from Injury or to correct a congenital anomaly of a Dependent child. Treatment rendered to correct a condition resulting from Injury must be incurred within the one-year period following the date of Injury.
- 4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- 5) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- 6) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining dental services. Charges for emergency dental care outside of the U.S. are covered; assignment of benefits does not apply to such benefits and all charges will be converted to U.S. currency denominations prior to calculation.
- 7) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- 8) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance unless the actions giving rise to the injuries result from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- 9) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- 10) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- 11) **Miscellaneous fees.** Miscellaneous fee charges for, including but not limited to, after hour, data analysis, handling and conveyance, lab stat charges, interpretation and report preparation, shipping and handling, and telephone consultation.

- 12) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- 13) **No listing.** Services which are not included in the list of covered dental services.
- 14) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- 15) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- 16) **Not accepted practice.** Charges for or in connection with experimental procedures or treatment methods not provided in accordance with accepted standards of medical, dental, psychiatric or other specialty practice.
- 17) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
- 18) **Occupational.** Care and treatment of an Injury or Sickness that is Occupational - that is, arises from work for wage or profit including self-employment, whether or not the injured person is required to be covered under any law for compensation for such injuries. The Plan Administrator has sole discretion to determine if an Injury or Sickness is Occupational.
- 19) **Office Fees.** Any charges resulting from the failure to keep a scheduled visit with a Physician or other provider, completion of any insurance forms.
- 20) **Orthognathic Procedures.** Services to change the size or alignment of the jaw.
- 21) **Personalization.** Personalization of dentures.
- 22) **Relative providing services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, grandparent or grandchild whether the relationship is by blood or exists in law.
- 23) **Replacement.** Replacement of lost or stolen appliances.
- 24) **Sales Taxes, shipping and mailing charges.**
- 25) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or attempted suicide while sane unless the result of an act of domestic violence or a medical condition (including both physical and mental health conditions).
- 26) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- 27) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- 28) **Telephone consultations, internet consultations, missed appointments** or the completion of a claim form.

- 29) **Third Party Liability.** Care for Injury or Sickness that results from the actions of a third party, whether or not such third party is able to reimburse the Covered Person for such care. Upon compliance by the Covered Person with requirements of the Section "Subrogation, Right of Reimbursement, and Third Party Recovery Provisions" in this Document the Plan Administrator may provide benefits for such charges subject to the Plan's right of recovery.
- 30) **Temporomandibular Joint Dysfunction.** Services, supplies, care or treatment of Temporomandibular Joint Syndrome
- 31) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- 32) **Treatment before onset.** Charges, whether or not recommended by a Physician, for treatment for genetically predisposed diseases, disorders or conditions prior to onset of the disease, disorder or condition.
- 33) **War.** Any loss, whether as a member of the armed forces or as a civilian, that is due to a declared or undeclared act of war.

CLAIM PROVISIONS

Filing claims properly and in a timely manner will help avoid delays in adjudication and facilitate prompt payment of any benefits due. Using a participating provider will help reduce claim filing issues. These providers will normally file claims for Covered Persons for covered services. Although a provider may file your claim, it is the Covered Person's responsibility to make sure that a proper claim has been filed. In the event that additional information is requested to complete a claim, it is the Covered Person's responsibility to make sure that a response is provided.

Benefits are based on the Plan's provisions at the time the charges were incurred. The Plan Administrator has the final and ultimate responsibility for claim decisions and payment of Plan benefits.

A **properly filed claim** is a written statement or claim form regarding medical or dental services which provides sufficient information substantiating the claim to allow the Plan to accurately and promptly determine available benefits for covered services. Claims from providers must be submitted on a CMS 1500, UB04, their successors, or other forms as approved by the Plan. Electronic claims may accepted by the Plan from providers of services if they meet the requirements of federal law under the Health Insurance Portability and Accountability Act (HIPAA.) A properly filed claim would also include an itemized statement of services from the provider and additional information including medical records and other appropriate information when requested by the Plan.

When a Covered Person is submitting a claim instead of the provider of services they must included the following information:

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

Forward claims to the Claims Administrator at this address:

Frates Benefit Administrators
P. O. Box 269001
Oklahoma City, Oklahoma 73126-9001
(405) 290-5696 or (800) 850-7166

Providers may find additional electronic claim filing information at www.clfrates.com/edipayor.stm.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator as soon as possible after services are incurred. Claims must be submitted within 12 months from the date of service in order to receive consideration for payment. At the sole discretion of the Plan Administrator this requirement may be waived when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant, provider and other appropriate entities.

DENTAL EXAMINATIONS AND SECOND OPINIONS

In determining benefits, the Plan reserves the right to have a Covered Person seek an independent dental evaluation. The Plan also reserves the right to have a Covered Person seek a second dental opinion.

CLAIM ADJUDICATION, DECISION NOTIFICATION and PAYMENT of BENEFITS

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Covered Person with a written notice of this denial. This written notice will be provided within 30 days after receipt of the complete and properly filed claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Covered Person wishes to submit the claim for review.

A Covered Person will be notified within 30 days of receipt of the claim as to the acceptance or denial of a claim.

If special circumstances beyond the control of the Plan Administrator require a 15-day extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Covered Person. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim.

Payment of Benefits

Following satisfaction of the deductible and out-of-pocket requirements, payment of Covered Expenses will be made to the Covered Person, Covered Person's estate or heirs, unless the Covered Expenses have been assigned to the provider. Any payment made by the Plan in good faith shall fully discharge the Plan to the extent of the payment.

The Plan may pay benefits that are later found to be greater than the Allowable Charge. The Plan has 24 months after the payment is made to recover the overpaid amount from the claimant or health care provider to which it was paid. The 24-month time period does not apply if the payment was made because of fraud committed by the claimant or health care provider, or if the claimant or health care provider has otherwise agreed to make a refund for overpayment of a claim.

Facility of Payment of Benefits

If a Covered Person is a minor or otherwise not competent to give valid receipt for payment of any benefit, all or any portion of the medical expenses benefits provided by the Plan may be paid directly to the provider of the benefits. Any payment made by the Plan in good faith shall fully discharge the Plan to the extent of the payment.

Legal Action

No action at law or in equity shall be brought to recover under the Plan prior to the expiration of 60 days after a claim has been filed. All actions must be brought within three years of the date the claim is filed.

CLAIMS REVIEW PROCEDURE

A Covered Person or the Covered Person's authorized representative, provided that such authorization has been made in writing and provided to the Plan, has the right to request a review ("Appeal") of any adverse benefit determination regarding (1) contractual relationships, coverage, payment or reimbursement for health care services, or (2) medical necessity, propriety, effectiveness or efficiency. The Plan's appeal process must be exhausted before seeking other available remedies in the event of a disputed claim.

The Plan offers two internal review levels. The first review level is an evaluation by an appropriately qualified person who was uninvolved with the adverse benefit determination (a "Level-One Appeal"). The second review level is an evaluation by the Plan Administrator or their representative, who was uninvolved in either the adverse benefit determination or the Level-One Appeal decision (a "Level-Two Appeal"). An Employee or the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S. Department of Labor Office and/or the State insurance regulatory agency. Finally, a Covered Person always has a right to bring a civil action under the appropriate state or federal law after exhausting the Plan's appeal process.

Participation in any Appeal process waives any privilege of confidentiality the Covered Person may have regarding medical records that any person examines or may examine in connection with the reviewed condition during the Appeal process.

To begin the Appeal process a Covered Person must do the following:

1. Make an oral or written Appeal request at the telephone number or address provided below within 180 days of the Appealed decision's adverse benefit determination. Covered Persons making oral requests will be sent an Appeal Form to complete and return.
2. An appeal coordinator will evaluate all requests regarding **contractual relationships, coverage, payment or reimbursement for health care services**. A physician, in consultation with appropriate clinical peers, will evaluate all requests regarding **medical necessity, propriety, effectiveness or efficiency**.
3. A Covered Person is responsible for providing all documentation supporting the Appeal request at the time of the request. The Plan will evaluate a request based on the information in its possession.
4. The Plan will provide the Covered Person and the Covered Person's requesting provider a written notification of its decision within thirty (30) days of receiving a written Appeal request or a completed Appeal form.

Contact Information:

Frates Benefit Administrators:

Appeal Coordinator
P.O. Box 269001
Oklahoma City, Oklahoma 73126-9001
Telephone: (405) 290-5696
FAX: (405) 290-5798

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses. All other plan provisions, exclusions and limitations will apply. Any part of an Allowable Charge that is paid or contractually reduced by a plan that is primary to this Plan will not be covered.

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

- 1) Group or group-type plans, including franchise or blanket benefit plans.
- 2) Any plan of prescription drug coverage
- 3) Blue Cross and Blue Shield group plans.
- 4) Group practice and other group prepayment plans.
- 5) Federal government plans or programs. This includes Medicare.
- 6) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- 7) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

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

Medicare Provisions, Working Aged. This Plan has elected to determine coordination with Medicare with respect to the working aged or dependents of the working aged on the basis of the size of the Employer that provides the Covered Person's eligibility. The Plan will treat such Covered Person, whose eligibility is established by an Employer with fewer than 20 Employees as determined by the Social

Security Act, as a Covered Person in "small employer" group health plan. As such benefits will be determined according to the provisions of this Section, with Medicare as the Primary Plan. Covered Persons whose eligibility is established on the basis of the Employee's employment with an Employer with 20 or more Employees, will have their claims processed by this Plan as the Primary Plan.

Prescription Drug Plans. This plan will not coordinate any benefits for services covered under the Prescription Benefits of this Plan. In the event that another prescription plan is used for a primary payment no benefit is payable under this Plan.

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

- 1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- 2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special rule. If the person covered directly is a Medicare beneficiary, and Medicare is secondary to Plan B, and Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:

- (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination as outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- 1) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
 - 2) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

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

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person is requested to give this Plan the information it asks for about other plans and their payment of Allowable Charges.

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

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

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

SUBROGATION, RIGHT OF REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

In the event a Covered Person receives any benefits arising out of any injury, accident, event, or incident for which the Covered Person has, may have, or asserts any claim or right to recovery under any theory of law or equity, tort, contract, statute, regulation, ordinance or otherwise against any other person, entity or source including, without limitation, any third party, insurer, insurance, and/or insurance coverage (e.g., uninsured and underinsured motorist coverage, personal injury coverage, medical payments coverage, workers' compensation, etc.), then any payment or payments made by the Plan to Covered Person for such benefits shall be made on the condition and with the agreement and understanding that the Plan will be reimbursed by Covered Person and Covered Person's representatives, including, without limitation, attorneys, agents, and all persons acting for, in concert with, or at the direction of or on behalf of, Covered Person to the extent of, but not to exceed the amount or amounts received by Covered Person from such person, entity or source by way of any agreement, settlement, judgment or otherwise.

The Plan shall be subrogated to all rights of recovery the Covered Person has against any party potentially responsible for making any payment to Covered Person as a result of any injury, damage, loss or illness Covered Person sustains to the full extent of benefits provided or to be provided by the Plan to Covered Person or on Covered Person's behalf with respect to that illness, injury, damage or loss immediately upon the Plan's payment or provision of any benefits to Covered Person or on Covered Person's behalf. The Plan's recovery, subrogation and reimbursement rights provided herein exist even where a party allegedly at-fault or responsible for any loss, injury, damage or illness Covered Person sustains does not admit responsibility and regardless of the designation or characterization given to the funds Covered Person receives or agrees to be disbursed from that party or that party's representative.

Covered Person also agrees to notify the Plan of Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation with respect to any matter for which Covered Person has obtained or will obtain any benefits from the Plan. Covered Person will be required to provide all information requested by the Plan or its representative regarding any such claim.

To the extent the Plan has paid benefits to Covered Person or on Covered Person's behalf, the Plan shall have a first priority, a first lien, and a first right to 100% of any payments or monies received by Covered Person from any other person, entity or source arising out of any claims or causes of action Covered Person has, may have, or asserts in connection with the occurrence, incident, accident, injury, illness or event for which the Plan paid any benefits to Covered Person or any third party on Covered Person's behalf. Covered Person agrees to hold, as trustee (or co-trustee) in trust (whether express, implied, constructive or resulting) for the benefit of the Plan all funds Covered Person receives in payment of or as compensation for any injury, illness, damage and loss Covered Person sustained resulting from any such event, incident, accident, injury, illness or occurrence. Any such amounts received by, on behalf of, with the consent of, or at the direction of Covered Person, or to which Covered Person is entitled to receive or direct payment, or over which Covered Person exercises any control, are deemed and shall be considered and treated as assets of the Plan. Failure to hold such funds in trust or to abide by these plan terms will be deemed a breach of Covered Person's fiduciary duty to the Plan. The Plan has a right of subrogation or reimbursement before any funds are paid to Covered Person from the responsible source and no attorneys' fees or costs may be subtracted from such amount. The Plan may, at its option and sole discretion, exercise either its subrogation and/or its repayment rights. The Plan is also entitled to any funds Covered Person receives or is entitled to receive regardless of whether or not the payment represents full compensation to Covered Person. The Plan expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with the Plan's rights herein.

The Plan may further require that (i) Covered Person utilizes the services of attorneys, representatives or agents who will execute a reimbursement agreement and who will not assert the make whole and common fund rule or doctrines, and (ii) Covered Person agrees to terminate any relationship with anyone who refuses to do so, or benefits will not be payable under the Plan in connection with that matter. The Plan is also entitled to receive and has priority to receive the first funds from payments received by Covered Person until the Plan has been repaid for all sums expended. Covered Person shall execute and deliver any instruments and documents reasonably requested by the Plan and shall do whatever is necessary to fully protect all the Plan's rights. Covered Person shall do nothing to prejudice the rights of the Plan to such reimbursement and subrogation, including, without limitation, any attempt by Covered Person or others to have payments characterized as non-medical in nature (e.g., for emotional distress, pain and suffering, embarrassment, mental anguish, loss of consortium, etc.) or to direct or consent to have payments made to others (e.g., to or on behalf of relatives, attorneys, agents, representatives or friends).

As further security for the Plan's rights to such reimbursement and subrogation, the payment of benefits may be withheld until Covered Person has executed a reimbursement agreement. If Covered Person fails to reimburse the Plan after receiving a recovery addressed in this Subrogation and Right of Reimbursement portion of the Plan, the Plan may, in addition to all other rights it has against Covered Person for such sums, offset the recovery amount against Covered Person's future medical expenses up to the extent of the amount recovered by Covered Person. Additionally, Covered Person shall be fully responsible for the actions of Covered Person's representatives, attorneys, agents, and all persons acting for, on behalf of, in concert with, or at the direction of Covered Person regarding the Plan or Covered Person's obligations described herein. Covered Person shall be responsible to ensure that such persons cooperate and comply with Covered Person's obligations herein. If Covered Person or Covered Person's agents, attorneys or any other representative fails to fully cooperate with any subrogation, reimbursement, or repayment efforts, or directly or indirectly hinders, impedes, or interferes with any such efforts, Covered Person shall be responsible to pay to the Plan all attorney's fees and costs incurred by or on behalf of the Plan in connection with such efforts. Additionally, the Plan may, in the discretion of Plan Administrator, terminate Covered Person's participation in the Plan. In the event that any claim is made that any wording, term or provision set forth in this Subrogation and Right of Reimbursement portion of the Plan is ambiguous or unclear, or if any questions arise concerning the meaning or intent of any of its terms, the Plan through its Plan Administrator, shall have the sole authority and discretion to construe, interpret and resolve all disputes regarding the interpretation of any such wording, term or provision.

If it becomes necessary for the Plan to enforce this provision by initiating any action against Covered Person, then Covered Person agrees to pay the Plan's attorney's fees and costs associated with the action if the Plan prevails in that action. The Plan may offset any such fees and costs against Covered Person's future dental expenses.

The Plan's subrogation and reimbursement rights described herein are essential to ensure the equitable character of the Plan and its financial soundness, and to ensure that funds are recouped and made available for the benefit of all Covered Persons under the Plan collectively.

COBRA CONTINUATION OPTIONS

Applicable only to qualified beneficiaries whose eligibility arises from the employee's employment by an employer subject to COBRA. An employer exempt from COBRA and not subject to these provisions is one that normally employed fewer than 20 employees during the preceding calendar year, or as otherwise determined to be exempt.

The COBRA requirements to offer continuation coverage under certain circumstances are a function of your employment with an employer that provides group health benefits. Your right to continue under the Plan terminates when your Employer no longer participates in the Oklahoma Lumbermen's Association - Health Plan.

Please contact your Employer if you have questions regarding your COBRA options.

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happen:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse become entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your Employer in accordance with your Employer's requirements.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of

continuation coverage. **You must provide this notice to your Employer in accordance with your Employer's requirements.**

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

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

Keep Your Plan 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.

Plan Contact Information

Oklahoma Lumbermen's Association
2801 Lincoln Blvd., Suite 237
Oklahoma City, OK 73105
(405) 602-5384

PRIVACY PROVISIONS

GENERAL OVERVIEW. As a Covered Person in the Plan, you and your medical care providers are required to communicate certain information to the Plan, and its designees such as the claims administrator, in order to have your benefit claims processed in an accurate and prompt manner. The confidentiality of this information and your privacy are very important to us.

In the daily operation of the Plan, we may use your information to facilitate treatment, payment and other healthcare operations. We always guard your privacy and disclose only the minimum information necessary to support those functions. For the most part, we do not disclose information about you or a family member except to facilitate payment for services or to comply with the cost management provisions of the Plan.

We will provide you with the Plan's "Notice of Privacy Practices" as one component of compliance with federal and state guidelines. This information will explain to you special procedures that will be instituted to allow you to control and manage your health information and also describe to you any policies regarding disclosure of information to the Plan Sponsor.

If you have any questions about the use of personal information, please contact the Plan Administrator or the claims administrator.

Protected Health Information (PHI). The Plan shall conform with the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the 'HIPAA Privacy Rule') by establishing the extent to which the Employer and Plan Sponsor will receive, use, and/or disclose PHI.

Compliance with HIPAA Privacy Rule. The Plan may disclose PHI (as defined below) to employees of the Plan Sponsor with employee benefits responsibility or to employees with oversight responsibility for third party administrator claims administration. Access to and use by such individuals must be restricted to plan administration functions that the Plan Sponsor performs for the Plan. The applicable claims procedures under the Plan shall be used to resolve any issues of noncompliance by such individuals. The Plan may disclose PHI to such individuals only if the Plan Sponsor certifies that the Plan documents have been amended to incorporate the following specific provisions, and the Plan Sponsor agrees to comply with them. The Plan Sponsor will:

- (1) not use or further disclose PHI other than as permitted by the Plan documents or as required by law;
- (2) ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- (3) not use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (4) report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures provided for of which it becomes aware;
- (5) make available to Covered Persons their PHI in accordance with 45 C.F.R. § 164.524;
- (6) make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. §164.524;

- (7) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (8) make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request for purposes of determining compliance by the Plan with applicable regulations regarding use and disclosure of PHI; and
- (9) if feasible, return or destroy all PHI 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 purposes for which the 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 infeasible; and
- (10) ensure that adequate separation between Plan and the Plan Sponsor is established.

Designation of Component Subject to the HIPAA Privacy Rule. The Plan provides various types of benefits to Covered Persons, including dental benefits. In accordance with 45 C.F.R. § 164.504(c)(3)(iii), the portion of the Plan that would be considered to be a 'group health plan' (as defined in 45 C.F.R. § 160.103) if such portion was a separate plan will be the only portion subject to the Privacy Rule and this part.

Definition of 'PHI.' For purposes of this part, 'PHI' is 'Protected Health Information' as defined in 45 C.F.R. § 164.501, which is individually identifiable health information that is maintained or transmitted by a covered entity, as defined in 45 C.F.R. § 164.104."

Designation of Privacy Officer. The Executive Vice President of the Plan Sponsor is designated as the Privacy Official for the Plan, and the Privacy Official shall be responsible for the development and implementation of policies and procedures of the Plan necessary to comply with the Privacy Rules and shall provide further information about matters covered by the Notice of Privacy Practices that is provided to Covered Persons in the Plan.

Designation of Contact Person. The Executive Vice President of the Plan Sponsor is designated as the Contact Person for the Plan, and the Contact Person shall be responsible for receiving complaints from Covered Persons in the Plan.

Required Separation between the Plan and the Employer. In accordance with the Privacy Rule, the Oklahoma Lumbermen's Association Privacy Policy provides a description of the employees, classes of employees, or workforce members under the control of the Employer who may be given access to individuals' PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan. Such list reflects the employees, classes of employees, or other workforce members of the Employer who receive individuals' PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer provides for the Plan. These individuals will have access to individuals' PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals' PHI in violation of, or noncompliance with, the provisions of this section.

The Employer will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Oklahoma Lumbermen's Association Dental Plan is the dental benefit plan of Oklahoma Lumbermen's Association, also called the Plan Sponsor. It is administered by the Plan Administrator, the Employee Benefits Committee of the Oklahoma Lumbermen's Association, in accordance with the provisions of ERISA. The Plan Administrator is appointed by the President of the Board of Directors of the Plan Sponsor.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits or the amount, manner and time of payment of any Plan benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

DUTIES OF THE PLAN ADMINISTRATOR

- (1) To administer the Plan in accordance with its terms.
- (2) To construe and interpret the Plan, including the right to resolve and remedy any ambiguities, inconsistencies or omissions with respect to any terms and provisions of the Plan.
- (3) To decide disputes which may arise relative to a Covered Person's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the plan documents and all other records pertaining to the Plan.
- (6) To appoint a claims administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

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

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the plan documents to the extent that they agree with ERISA.

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

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

GENDER AND NUMBER. As used in this plan document, the masculine reference shall include the feminine and the singular shall include the plural.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

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

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

ENTIRE CONTRACT. The Plan (as amended) and any individual enrollment applications shall constitute the entire contract of coverage. Any statement made by the Plan Administrator and its designees, including the Claims Administrator, are deemed to be representation and not warranties. Such statements will not invalidate the Plan as stated in the Plan Document unless contained in a written statement signed by the Plan Administrator and the Covered Person.

PRIOR FAILURE TO ENFORCE AND WAIVER. No provision of the Plan shall be waived, modified or made unenforceable as the result of the Plan's prior failure to apply or enforce such provision. No waiver of the Plan's provisions can be enforced unless it is in writing and signed by the Plan Administrator. The authority to waive any provision of this Plan cannot be delegated.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Plan Sponsor intends to maintain the Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

RENEWABILITY

The Plan may not deny an Employer continued access to the same or different coverage under the Plan, other than:

- (1) for nonpayment of contributions;
- (2) for fraud or other intentional misrepresentation of material fact by the Employer;
- (3) for noncompliance with material provisions of the Plan;
- (4) because the Plan is ceasing to offer coverage in a geographic area; or
- (5) in the case of benefits offered through a network, there is no longer any Covered Person enrolled through the Employer who lives, resides or works in the service area of the network and the Plan applies this paragraph uniformly without regard to the claims experience of Employers or any health status-related factor in relation to Covered Persons.

ERISA DISCLOSURES AND INFORMATION

PLAN NAME, NUMBER AND TYPE:

Plan Name. Oklahoma Lumbermen's Association Dental Plan (the "Plan")

Plan Number. 501

Plan Type. Group Plan (Employee Welfare Benefit Plan) providing dental benefits.

NAME, ADDRESS, TELEPHONE NUMBER AND TAX IDENTIFICATION NUMBER OF PLAN SPONSOR:

Oklahoma Lumbermen's Association
2801 Lincoln Blvd. Ste 237
Oklahoma City, OK 73105
(405) 602-5384
EIN: 73-1298666

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR:

The Employee Benefits Committee of the Oklahoma Lumbermen's Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105
(405) 602-5384

PARTICIPATING EMPLOYERS:

A complete updated list of Employers participating in the Plan may be obtained upon written request to the Plan Administrator and is also available in the office of the Plan Administrator for examination.

NAMED FIDUCIARY:

Oklahoma Lumbermen's Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105
(405) 602-5384

NAME AND ADDRESS OF THE AGENT FOR SERVICE OF LEGAL PROCESS:

Oklahoma Lumbermen's Association
2801 Lincoln Blvd Ste 237
Oklahoma City, OK 73105
(405) 602-5384

SOURCE OF CONTRIBUTIONS AND PLAN FUNDING:

The Plan is self-insured by Employers and Covered Persons. Required contributions are determined by the Plan Administrator. Each respective Employer then determines its contribution and those of its Covered Persons toward the required contributions of the Plan.

PLAN YEAR:

The Plan year for purposes of maintaining the Plan's records is the annual period from January 1 through December 31.

TYPE OF ADMINISTRATION:

The Plan is self administered by the Plan Administrator. However, the Plan Administrator has by contract obtained the performance of certain administrative functions such as the review, processing and payment of claims from the claims administrator. The name, address and telephone number of the claims administrator is:

Frates Benefit Administrators
P.O. Box 269001
Oklahoma City, Oklahoma 73126-9001
405-290-5666 or 888-244-5096

The Claims Administrator provides claims administration for the Plan and does **not** insure or otherwise guarantee benefits.

ELIGIBILITY:

The Plan's provisions relating to eligibility are described in detail in section titles "Eligibility, Funding, Effective Date and Termination Provisions".

DESCRIPTION OF BENEFITS:

The Plan provides Covered Persons with the payment of or reimbursement of certain eligible expenses, which are described in detail in the section, Dental Benefits.

PROVISIONS LIMITING BENEFITS (Summary Only):

There are provisions that may result in ineligibility or in denial, loss, suspension, offset, reduction or recovery of benefits that a Covered Person might reasonably expect the Plan to provide. These provisions include, but are **not** limited to:

- deductibles and maximum annual limits;
- exclusions and limitations;
- subrogation, right of reimbursement and third party recovery rights of the Plan;
- coordination of benefits when a Covered Person is enrolled in more than one plan and the Plan is not the primary plan;
- effects of Medicare;
- reductions or denials due to services that are not generally accepted as appropriate, and/or which are not Medically Necessary, and/or which are considered as over-utilization;
- treatment, services and supplies that are excluded from coverage by the Plan, whether or not Medically Necessary;
- non-compliance with the Plan's claims filing deadlines.

These provisions are described in greater detail throughout this document.

ERISA RIGHTS STATEMENT

Your Rights. As a Covered Person in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (previously known as the Pension and Welfare Benefit Administration).

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report, if any is required by ERISA to be prepared. The plan administrator is required by law to furnish each Covered Person with a copy of any required summary annual report.

COBRA and HIPAA Rights. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the plan on the rules governing your COBRA continuation coverage rights, if applicable.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

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

BY THIS AGREEMENT, the Oklahoma Lumbermen's Association Dental Plan is hereby adopted and amended as shown.

IN WITNESS WHEREOF, this instrument is executed for the Oklahoma Lumbermen's Association and Welfare Benefit Corporation on or as of the day and year first below written.