

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

**GENERAL SYNOD, ASSOCIATE REFORMED PRESBYTERIAN CHURCH
DENTAL BENEFITS PLAN**

August 1, 2004

TABLE OF CONTENTS

INTRODUCTION.....	1
ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS.....	2
ELIGIBILITY	2
<i>Eligible Classes of Employees.....</i>	<i>2</i>
<i>Eligibility Requirements for Employee Coverage.....</i>	<i>2</i>
<i>Eligible Classes of Dependents.....</i>	<i>3</i>
<i>Eligibility Requirements for Dependent Coverage.....</i>	<i>4</i>
FUNDING.....	4
ENROLLMENT.....	4
<i>Enrollment Requirements.....</i>	<i>4</i>
<i>Timely or Late Enrollment.....</i>	<i>4</i>
<i>Open Enrollment Period.....</i>	<i>5</i>
<i>Special Enrollment Periods.....</i>	<i>5</i>
EFFECTIVE DATE	6
TERMINATION OF COVERAGE	6
SCHEDULE OF BENEFITS.....	9
DENTAL BENEFITS	9
DEFINED TERMS	10
DENTAL BENEFITS	12
<i>Deductibles.....</i>	<i>12</i>
<i>Deductible Amount.....</i>	<i>12</i>
<i>Family Unit Limit.....</i>	<i>12</i>
BENEFIT PAYMENT	13
MAXIMUM CALENDAR YEAR BENEFIT AMOUNT	13
LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC SERVICES.....	13
DENTAL CHARGES	13
COVERED DENTAL SERVICES	13
<i>Class I Services:.....</i>	<i>13</i>
<i>Class II Services:.....</i>	<i>13</i>
<i>Class III Services:.....</i>	<i>15</i>
<i>Class IV Services.....</i>	<i>16</i>
PREDETERMINATION OF BENEFITS.....	17
ALTERNATE TREATMENT	17
DENTAL EXCLUSIONS	17
HOW TO SUBMIT A CLAIM	19
WHEN CLAIMS SHOULD BE FILED	19
CLAIMS REVIEW PROCEDURE.....	20
COORDINATION OF BENEFITS.....	20
THIRD PARTY RECOVERY PROVISION	23
COBRA-TYPE CONTINUATION OPTIONS.....	24
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION.....	29
PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR	29
RESPONSIBILITIES FOR PLAN ADMINISTRATION.....	31
PLAN ADMINISTRATOR.....	31
DUTIES OF THE PLAN ADMINISTRATOR.....	32
PLAN ADMINISTRATOR COMPENSATION.....	32
CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.....	32
FUNDING THE PLAN AND PAYMENT OF BENEFITS	32
PLAN IS NOT AN EMPLOYMENT CONTRACT	32
CLERICAL ERROR.....	32
CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA.....	32
GENERAL PLAN INFORMATION.....	34

INTRODUCTION

This document is a description of the General Synod, Associate Reformed Presbyterian Church Dental Benefits Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain dental expenses.

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

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA-type elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease 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.

Dental care has become an increasingly common and expensive medical cost in recent years. Yet, dental health can be maintained easily through regular, routine care. Therefore, in addition to reimbursement for much of the cost of major procedures, the Plan encourages preventive and restorative dental care in order to avoid future, more costly major dental expenses.

If the Plan is terminated, amended, or benefits eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment, or elimination.

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

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

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

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

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

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

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

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

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA-Type Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Use and Disclosure of Protected Health Information. Explains the restrictions upon which General Synod, Associate Reformed Presbyterian Church may use and disclose a Participant's Protected Health Information.

ELIGIBILITY, FUNDING, ENROLLMENT, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of the Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage.

A person is eligible for Employee coverage from the first day that he or she is in a class eligible for coverage. A person is in an eligible class if he or she:

- (1) Routinely works for the Employer for compensation for at least 30 hours per week with compensation equal to or greater than a stipend equal to the minimum wage times the number of hours worked and is:
- (2) A salaried ordained minister serving a Church of the General Synod under the terms of a Call approved by his presbytery;
- (3) An Employee of the General Synod, General Synod Agency, or a Presbytery of the General Synod;
- (4) An Employee of Bonclarken, Due West Retirement Center, or Erskine College/Seminary;
- (5) A non-ordained employee of a Church of the General Synod.
- (6) Is a retired Employee who has completed 5 or more years of continuous service immediately prior to retirement (coverage beyond the Medicare age of eligibility will be limited to those covered by Medicare and benefits will be reduced by the amount paid by Medicare or Medicaid) and, for those retiring on or after August 1, 2002, has not reached the Medicare eligibility age (in addition to the 5-year continuous service requirement, the retiree must be at least age 55 and the years of continuous service and age must be equal to or greater than 65);
- (7) Is a student of theology, enrolled in an accredited School of Theology, under the care of a Presbytery of the Employer; or
- (8) Is an ordained ARP minister currently serving in Not-for-Profit Ministries who:
 - a. is not eligible for medical care benefits from other sources of employment; and
 - b. has participated continuously in the Medical Care Benefit Plan provided for Employees of the General Synod, Associate Reformed Presbyterian Church during the preceding five calendar years, and
 - c. has the approval of his Presbytery for such service.

If a person is in an eligible class, he or she becomes eligible for coverage:

- (1) on the effective date of the Plan if employed on that date, or
- (2) for hourly employees (other than Erskine College hourly employees), 90 days following the date he or she becomes employed after the effective date of the Plan; or
- (3) for salaried employees, and for hourly employees of Erskine College, on the date he or she becomes employed after the effective date of the Plan.

If a person is not in an eligible class, he or she becomes eligible for coverage on the date he or she enters an eligible class.

A former eligible Seminary Student or Employee of Outreach North America serving as an Intern who meets the requirements of # 1 above shall be considered as a new eligible Employee.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child may be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches any limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.
- (2) For a Dependent child who has reached the age of 19 but is less than 25 years of age, full-time student coverage continues only between semester/quarters if the student is enrolled or has made application to be enrolled as a full-time student in the next regular semester/quarter. If the student fails to return as a full-time student for reasons other than injury or illness, coverage will be terminated retroactively to the last day of the month preceding the month the student was scheduled to return as a full-time student. An eligible Dependent child who fails to return as a full-time student because of illness or injury may continue coverage if the Dependent child is enrolled as a student in the next regular grade/semester/quarter. A graduating senior will be covered under the Plan to the end of the month in which the student graduates plus an additional three (3) months after the date of graduation, provided he or she has not reached age 25, is not married, and is not covered under another group dental benefits plan.

The term "Spouse" shall mean the person 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.

The term "children" shall include natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption or Foster Children. Step-children 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. Grandchildren related to the Employee by blood or marriage may also be included as long as such children are primarily dependent upon the Employee.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

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 eighteen (18) 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.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (3) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage.

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

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

FUNDING

Cost of the Plan.

General Synod, Associate Reformed Presbyterian Church shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

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

ENROLLMENT

Enrollment Requirements.

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

Timely or Late Enrollment

- (1) **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.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

For Employees becoming eligible for coverage on or after August 1, 2002, "late" enrollments will be permitted only for those qualifying for enrollment during a SPECIAL ENROLLMENT PERIOD.

Open Enrollment Period

For Employees becoming eligible on or after August 1, 2002, there will be no OPEN ENROLLMENT PERIOD. For all other Employees, the final OPEN ENROLLMENT PERIOD was held in the month of July, 2002 for coverage effective August 1, 2002.

Each December, covered Employees will be able to make changes with respect to the following benefit decisions:

Enroll in and/or add dependent dental coverage. For persons that fail to enroll in the dental plan when first eligible, Dental Expense Benefits will be limited to initial and periodic exams, x-rays, cleanings and fluoride applications only until the person has been covered under the dental plan for 12 consecutive months from date of enrollment.

Benefit choices made during December will become effective January 1 and will remain in effect until the next January 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption), loss of coverage due to a Spouse's employment, or availability of dependent coverage due to a Spouse's employment.

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:

- a. The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- b. If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- c. The coverage of the Employee or Dependent who had lost the coverage was under COBRA or COBRA-type coverage and the COBRA or COBRA-type coverage was exhausted, or was not under COBRA or COBRA-type coverage 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.
- d. The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA or COBRA-type coverage or the termination of coverage or employer contributions, described above.

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

(2) **Dependent beneficiaries.** If:

- a. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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

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

- a. in the case of marriage, the date the completed request for enrollment is received;
- b. in the case of a Dependent's birth, as of the date of birth; or
- c. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

EFFECTIVE DATE

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

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

For the purposes of this plan, the necessary enrollment form(s) must be received by the employing agency within thirty-one (31) days of the Employee's eligibility date. If the necessary enrollment form(s) are not received by the employing agency within 31 days of the Employee's eligibility date, coverage will not be available except as stated in the sections **SPECIAL ENROLLMENT PERIODS** and **OPEN ENROLLMENT PERIODS**.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

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

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

- (1) The date the Plan is terminated.

- (2) The last day of the month in which the covered Employee ceases to be in one of the Eligible Classes, except that a graduating Seminary student will continue to be covered under the Plan to the end of the month in which the student graduates plus an additional three (3) months provided that they remain under the care of the presbytery and have not become eligible for coverage under another group dental benefits plan. (See the COBRA-Type Continuation Options.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) The last day of the month in which the covered Employee ceases active work for the Employer, except that:
 - (a) If he or she is disabled, coverage may be continued while disabled for up to six (6) months. To remain on the Plan after six (6) months of disability, such employee must be receiving Long Term Disability benefits through his or her Employer's group Long Term Disability plan;
 - (b) If he is a minister under the care of Presbytery and is actively seeking a pastorate, or is on an approved leave of absence or sabbatical, or if he or she is a professional lay employee of an agency of the Employer on an approved leave of absence or sabbatical, or if he or she is awaiting coverage as an employee of another agency of the Employer, coverage may be continued through the end of the month in which active work terminates plus an additional 12 months (Maximum period of 12 months from end of the month in which active work ceased. The maximum of 12 months includes any time off used for FMLA purposes.); or
 - (c) If he or she is an Employee of Erskine College/Seminary and has a contract for the ensuing school term, coverage may be continued between school terms; or
 - (d) If he or she is an Employee of Erskine College/Seminary and does not have a contract for the ensuing school term, coverage may be continued to the end of the month in which the school term ends plus an additional three (3) months provided they have not become eligible for coverage under another group dental benefits plan (See the COBRA-Type Continuation Options); or
 - (e) If he or she is not included in the two preceding categories and he or she is on a leave or absence or temporary layoff, coverage may be continued through the end of the month in which active work terminates plus an additional two (2) months; or
 - (f) If he or she retires and meets the eligibility requirements for Employee coverage, coverage may be continued, subject to the terms of the Plan. For those retiring on or after August 1, 2002, coverage may be continued to the retired Employee's attained Medicare eligibility age.

An Employee whose coverage is continued on this Plan based upon the provisions in 4 (a), (b), (c), (d), (e) or (f) above must pay premiums to remain on the Plan. Premiums must be paid on or before the beginning of each month of coverage. If premiums are not paid within thirty (30) days of their due date, coverage will end as of the last period for which premiums were paid.

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. 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, with the exception of an Employee returning to work directly from COBRA-type coverage. This Employee does not have to satisfy the employment Waiting Period

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 18 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 coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death, except as provided in the section Coverage for Dependents of Deceased Employees. (See also the COBRA-Type Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA-Type Continuation Options.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA-Type Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Coverage for Dependents of Deceased Employees. If an Employee dies, coverage may be continued on eligible Dependents (if already covered) until the earlier of:

- (1) The date the Dependent becomes eligible for other group dental care benefits (when the Dependent becomes eligible for Medicare or Medicaid, benefits will be reduced by the amount paid by Medicare or Medicaid);
- (2) The date the Dependent ceases to be in a class of eligible Dependents;
- (3) The date the Plan is terminated; or
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Premiums for the Spouse of a deceased Employee, or a Dependent child of the deceased Employee, will be at the Employee rate. Premiums for a Spouse and a Dependent child or Dependent children will be at the family rate.

Coverage for Dependents of Retired Employees. If a dependent loses coverage by reason of the retired Employee reaching Medicare eligibility age, coverage may be continued at the Employee rate (Family rate for a Spouse and child or Dependent children without a surviving Spouse) until the earlier of:

- (1) The date the Dependent becomes eligible for other group dental care benefits or Medicare;
- (2) The date the Dependent ceases to be in a class of eligible Dependents;
- (3) The date the Plan is terminated; or
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

SCHEDULE OF BENEFITS

Verification of Eligibility 1-800-

822-1274

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

Please read the sections **Alternative Treatment and Predetermination of Benefits**. **You will need to follow the guidelines outlined in those sections or reimbursement from the Plan may be reduced.**

DENTAL BENEFITS

Dental Deductible Amount per Calendar Year

Individual Deductible.....	\$ 50
Maximum Family Unit Deductible..... (May be satisfied by any number of family members)	\$150

The Deductible does not apply to Class I Preventive Services or to Class IV Orthodontic Services.

Dental Percentage Payable

Class I Preventive Services.....	100%
Class II Basic Services.....	80%
Class III Major Services.....	50%
Class IV Orthodontic Services.....	50%

Maximum Benefit Amounts

Calendar Year Maximum for Class I, II and III Services.....	\$1,500
Lifetime Maximum for Class IV Services.....	\$1,500

Calendar Year is defined as the period January 1 through December 31.

Note: No benefits (except for routine exams, cleanings, x-rays and fluoride treatments) are payable in the first 12 months of the Covered Person's coverage under the Dental Plan if he or she is a Late Enrollee*.

*A Late Enrollee is an Employee or Dependent of an Employee who enrolls in the Dental Plan other than during the first 31-day period in which he or she was first eligible.

DEFINED TERMS

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

Actively at Work means that, on the day coverage under the Plan would begin, an Employee is not absent from work due to an unapproved absence which is not related to the health of the employee.

Calendar Year means January 1 through December 31st of the same year.

Call means the process for establishing and maintaining an Employee relationship with a salaried, ordained minister of the Church serving in a Pastoral ministry of the Church.

Claimant means a person who is or was a covered eligible Employee or a covered eligible Dependent of an Employee.

COBRA-type means the coverage provisions for terminated employees generally comparable to coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended. Church plans are not subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Person is an Employee or Dependent who is covered under this Plan.

Dental hygienist means an individual who is licensed to practice dental hygiene and acting under the supervision of a dentist within the scope of the license in treating the dental condition.

Dental treatment plan means the dentist's report of recommended treatment which contains a list of the charges and dental procedures required for the dentally necessary care, any supporting x-rays, and any other appropriate diagnostic materials required.

Dentally necessary and **dental necessity** mean a treatment appropriate for the diagnosis and in accordance with accepted dental standards. The treatment must be essential for the care of the teeth and supporting tissues.

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

Emergency dental care means any dentally necessary treatment rendered or received as the direct result of unforeseen events or circumstances which require prompt attention.

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

Employer is General Synod, Associate Reformed Presbyterian Church

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

ERISA is the Employee Retirement Income Security Act of 1974, as amended. Church plans are not subject to ERISA.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

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

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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

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. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

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

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

Natural tooth means any tooth or part of a tooth that is formed by the natural development of the body. Organic portions of the tooth include the crown enamel and dentin, the root cementum and dentin, and the enclosed pulp.

Orthodontic treatment means the procedures which provide the corrective movement of teeth through the bone by means of an active appliance to correct a handicapping malocclusion (a malocclusion severely interfering with a person's ability to chew food).

Plan means the General Synod, Associate Reformed Presbyterian Church Dental Benefits Plan, which is a benefits plan for certain employees of General Synod, Associate Reformed Presbyterian Church and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

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.

Predetermination of benefits means review of a dentist's statement, including diagnostic x-rays, describing the planned treatment and expected charges.

Treatment means any dental consultation, service, supply, or procedure that is needed for the care of the teeth and supporting tissue.

Usual and Reasonable Charge is a charge which 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 will reimburse 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.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

Deductibles

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 Schedule of Benefits.

Family Unit Limit.

When the dollar amount shown in the Schedule of Benefits has been met 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 to a Covered Person for the dental charges in excess of the deductible amount. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM CALENDAR YEAR BENEFIT AMOUNT

The Maximum Calendar Year dental benefit amount is shown in the Schedule of Benefits.

LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIC SERVICES

The lifetime maximum benefit payable, while covered under this Plan, for orthodontic treatment is shown in the Schedule of Benefits.

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.

COVERED DENTAL SERVICES

Class I Services:

Preventive 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. This includes the cleaning and scaling of teeth. Limit of 2 per Covered Person each Calendar Year.
- (2) Complete series of x-rays (consisting of at least 14 films, including bitewings if necessary) or panoramic survey (maxilla and mandible film) every 3 years.
- (3) Bitewing films (limit of 4 bitewing x-rays per Calendar Year).
- (4) Intraoral and extraoral x-rays.
- (5) One fluoride treatment for covered Dependent children under age 19 each Calendar Year.
- (6) Space maintainers, including all adjustments made within 6 months of installation.
- (7) Removable or fixed inhibiting appliances to correct thumb sucking, including all adjustments made within 6 months of installation.

Class II Services:

Basic Dental Procedures- Non Restorative

- (1) Emergency oral exam and emergency palliative treatment considered for payment as a separate benefit only if no other treatment (except x-rays) is rendered during the visit.

- (2) Sealants on the occlusal surface of a permanent posterior tooth for persons under age 17, once per tooth in any 36 consecutive months.
- (3) Consultation, including specialist consultations, limited as follows:
 - (a) considered for payment only if billed by a dentist who is not providing operative treatment;
 - (b) benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan.
- (4) Histopathological examination.
- (5) Biopsy.
- (6) General anesthesia and intravenous sedation when administered in the dentist's office.
- (7) Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care:
 - (a) extractions – uncomplicated, surgical extractions and removal of impacted teeth (soft tissue, partially or completely bony);
 - (b) root removal – exposed roots;
 - (c) surgical removal of residual tooth roots (cutting procedure);
 - (d) incision and removal of foreign body from soft tissue;
 - (e) suture of soft tissue wound;
 - (f) frenectomy;
 - (g) surgical exposure of impacted or unerupted tooth to aid eruption (but not for orthodontic purposes);
 - (h) oral incision and drainage of abscess – intraoral or extraoral;
 - (i) sialolithotomy;
 - (j) closure of salivary fistula;
 - (k) excision of lesions, malignant or benign tumors;
 - (l) transplantation of tooth or tooth bud;
 - (m) removal of foreign body from bone (independent procedure);
 - (n) radical resection of bone for tumor with bone graft;
 - (o) maxillary sinusotomy for removal of tooth fragment or foreign body;
 - (p) oroantral fistula closure;
 - (q) sequestrectomy of osteomyelitis.
- (5) Endodontics – treatment of dental pulp, including root canal therapy:
 - (a) pulp cap – direct or indirect
 - (b) pulpotomy (excluding first restoration) –**limited to treatment of primary teeth only**
 - (c) root canals – one canal, two canals or three canals

Root canals are limited to permanent teeth only and include necessary x-rays and cultures but exclude final restoration.
 - (d) apexification (per treatment visit)
 - (e) apicoectomies (per tooth)
 - (f) root amputation (per root)
 - (g) hemisection
- (6) Periodontics – Adjunctive Services

Non-surgical treatment of gum or area surrounding tooth

 - (a) provisional splinting – intracoronal or extracoronal
 - (b) root planing – entire mouth or per quadrant

Root planing is payable only when x-rays and pocket depth summaries

of each tooth involved confirm presence of periodontal disease.

- (7)** Restorative Dentistry (excluding inlays, crowns and bridges)
 - (a) amalgam restorations – primary and permanent teeth
 - (b) silicate restorations (silicate cement per restoration)
 - (c) resin restorations
 - (d) stainless steel crowns – primary or permanent teeth – **available to children under age 19 only**
 - (e) prefabricated resin crown – **available to children under age 19 only**
- (8)** Recementation of inlays, crowns, bridges and space maintainers (only for space maintainers defined as covered services)
- (9)** Repair of complete and partial denture, acrylic
 - (a) repair of complete denture, acrylic – broken base, replacement of missing or broken teeth (each tooth)
 - (b) repair of partial dentures, acrylic – repair of acrylic saddles on base, cast framework, repair or replacement of broken clasp, replacement of broken tooth - per tooth
- (10)** Repair of fixed appliances: repair of crowns and bridges

Class III Services:

Major Dental Services

- (1)** Periodontics – surgical services
 - Surgical treatment of gum or area surrounding tooth (including post-surgical visits)
 - (a) subgingival curettage (payable only when x-rays and pocket depth summaries for each tooth involved confirm presence of periodontal gum disease)
 - (b) gingivectomy or gingivoplasty – per quadrant or per tooth
 - (c) gingivectomy, osseous or muco-gingival surgery – per quadrant
 - (d) crown lengthening
- (2)** Oral surgery – alveolar or gingival reconstruction
 - (a) alveolectomy (with or without extractions (per quadrant)
 - (b) vestibuloplasty – uncomplicated or complicated
 - (c) remove exostosis – maxilla or mandible
 - (d) excision of hyperplastic tissue – per arch

- (3) Restorative**
 - (a) inlays and crowns –covered only when needed due to decay or traumatic injury
 - (b) crown build-up – in conjunction with a crown
 - (c) cast post and core – in conjunction with a crown
 - (d) cast post – as part of a crown
- (4) Repair of complete and partial dentures: relines - office or lab**
- (5) Prosthodontics – fixed. Services to replace one or more extracted teeth, bridge abutments and pontics**
- (6) Prosthodontics – removable. Services to replace one or more extracted teeth, bridge abutments and pontics.**
- (7) Complete and partial dentures. Fees for both complete and partial dentures and relining include adjustments within six months after installation. Precision attachments, overdentures, specialized techniques and characterizations are considered optional the expense for these shall be borne by the patient. All partials include conventional clasps and rests.**
 - (a) complete denture – upper or lower
 - (b) partial denture – upper or lower – acrylic base or predominately base cast with acrylic saddles
 - (c) removable unilateral partial denture – one piece predominately base casting, clasp attachments – per unit (including pontics)
 - (d) stress breaker
 - (e) stayplate – upper or lower
 - (f) temporary complete denture – upper or lower
 - (g) adjustments to complete or partial dentures (more than six months after installation)
 - (h) special tissue conditioning, per denture
 - (i) rebase complete or partial denture – upper or lower
 - (j) reline complete or partial denture – upper or lower
 - (k) adding teeth to existing partial denture to replace extracting natural teeth
 - (l) adding clasp to existing partial denture as a result of extracting natural teeth

Class IV Services

Orthodontic Treatment and Appliances

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

- (1) Minor treatment for tooth guidance**
 - (a) removable appliance therapy
 - (b) fixed or cemented appliance therapy
- (2) Interceptive orthodontic treatment**
 - (a) removable appliance therapy
 - (b) fixed or cemented appliance therapy
- (3) Comprehensive orthodontic treatment**
 - (a) diagnosis (including exam, x-rays and study models) and initial orthodontic appliances
 - (b) active orthodontic treatment
 - (c) passive orthodontic treatment

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be \$300 or more, a predetermination of benefits form can be submitted.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address:

Kanawha HealthCare Solutions, Inc.
P. O. Box 1000
Lancaster, South Carolina 29721
800-822-1274

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

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

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.

DENTAL EXCLUSIONS

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Before coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan.
- (3) **Broken appointments.** Charges for broken or missed dental appointments.
- (4) **Cosmetic.** Any treatment for cosmetic purposes. Facings on crowns or pontics beyond the second bicuspid, or replacement of more than 32 teeth will be considered cosmetic.
- (5) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (6) **Excess charge.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

- (7) **Felonious behavior.** Charges for services received as a result of Injury or Sickness caused or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, assault or other felonious behavior, or by participating in a riot or public disturbance.
- (8) **Government.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (9) **Hospital charges.** Hospital or facility charges for room, supplies or emergency room expenses; or routine chest x-rays and medical examinations prior to oral surgery.
- (10) **Hygiene.** Oral hygiene, plaque control programs, nutritional counseling or dietary instructions.
- (11) **Implants.** Insertion of implants or the related appliances (or the surgical removal of implants).
- (12) **Initial placement.** Initial placement of any prosthetic appliance or fixed bridge unless such placement is needed to replace one or more natural teeth. Such replacement must be done within six (6) months following the extraction of the natural tooth or teeth.
- (13) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (14) **No listing.** Services which are not included in the list of covered dental services.
- (15) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (16) **Not Medically or Dentally Necessary.** Care and treatment that is not Medically or Dentally Necessary.
- (17) **Occupational.** Care and treatment of an Injury or Sickness that, in either case, is occupational -- that is arises from work for wage or profit, including self-employment.
- (18) **Personal supplies.** Charges for personal supplies or equipment, including, but not limited to, water piks, toothbrushes, or floss holders.
- (19) **Personalization.** Personalization of dentures.
- (20) **Plan design.** Charges excluded or limited by the Plan design as stated in this document.
- (21) **Precision or semi-precision attachments.**
- (22) **Relative.** 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, whether the relationship is by blood or exists in law.
- (23) **Replacement.** Replacement of lost or stolen appliances, for duplicate prosthetics, or for athletic mouth guards.
- (24) **Replacement.** Replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five (5) years of the date of the last placement of these items. This five (5) year limitation will not apply in the event of an accidental bodily injury.
- (25) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (26) **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, or restoring the bite (occlusion).

- (27) **Temporomandibular Joint Dysfunction (TMJ).** Diagnosis or treatment of temporomandibular joint dysfunction, by any name called.
- (28) **War.** Any loss that is due to a declared or undeclared act of war.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a claim to submit for payment that person must:

- (1) Have the Dentist complete the provider's portion of the form.
- (2) Send all the Claims to the Claims Administrator at this address:

Kanawha HealthCare Solutions, Inc.
P. O. Box 1000
Lancaster, SC 29721
(800) 822-1274

If a Claim form is required, the Claims Administrator will furnish the necessary form and instructions for its completion.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Administrator within 12 months of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined or reduced unless it is not reasonably possible to submit the claim in that time. This 12-month period will not apply 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. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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 Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the 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 Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

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

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

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

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

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.

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) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) 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.
- (6) 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-Preferred only plans: This Plan will not consider any charges in excess of what an HMO or Preferred provider has agreed to accept as payment in full. Also, when an HMO or Preferred plan is primary and the Covered Person does not use an HMO or Preferred provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or Preferred plan had the Covered Person used the services of an HMO or Preferred 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.

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").
 - (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 or COBRA-type 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 rules 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.
- (3) 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.
- (4) If a Plan Participant 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 will give this Plan the information it asks for about other plans and their payment of allowable charges.

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

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

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

Failure to Notify Plan Administrator of Other Coverage. Should a Plan Participant become entitled to coverage under another group health plan described in item (3) above, or entitled to benefits under Medicare, and subsequently fails to notify the Plan Administrator within fifteen (15) days of the date he/she first becomes entitled to other coverage after the date of COBRA-type election (the "Notification Period"), the Plan expressly reserves the right to retroactively cancel COBRA-type coverage and seek reimbursement of all benefits paid after the date of expiration of the Notification Period. The Plan shall refund any COBRA-type premiums remitted, less any claims paid, subsequent to the date of expiration of the Notification Period.

THIRD PARTY RECOVERY PROVISION

If a Covered Individual receives any benefits arising out of an injury or illness for which the Covered Individual (or the Covered Individual's guardian or estate) has, may have, or asserts any claim or right to recovery against any person, entity, corporation, or insurance coverage, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Covered Individual (or the Covered Individual's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Covered Individual (or the Covered Individual's guardian or estate) from: (1) any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, personal injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or fund (this specifically includes, but it not limited to, the Covered Individual's own insurance coverage) and/or (2) any person, entity, corporation or plan as a result of judgment, settlement, arbitration award, or any other arrangement. By accepting benefits under this Plan, the Covered Individual (or the Covered Individual's guardian or estate) acknowledges and agrees that this Plan will be reimbursed in full before any amounts including, but not limited to, attorney fees incurred by the Covered Individual (or the Covered Individual's guardian or estate) are deducted from the insurance policy proceeds, judgment, settlement, or arbitration award.

Without limiting the preceding paragraph, this Plan will be subrogated to all claims, demands, actions and right of recovery against any person, corporation and/or other entity who has or may have caused, contributed to or aggravated the injury or condition which the Covered Individual claims an entitlement to benefits under this Plan, and to any no fault insurance coverage, uninsured insurance coverage, underinsured insurance coverage, person injury protection (PIP) insurance coverage, med-pay insurance coverage, other insurance policies or funds (this specifically included, but is not limited to, the Covered Individual's own insurance coverage). The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which the Covered Individual (or the Covered Individual's guardian or estate) has, may have, or asserts a cause of action or claim.

The Covered Individual (or the Covered Individual's guardian or estate) specifically agrees not to do anything to prejudice this Plan's rights to reimbursement or subrogation. In addition, the Covered Individual (or the Covered Individual's guardian or estate) agrees to cooperate fully with the Plan and Plan Administrator in asserting and protecting the Plan's subrogation rights. The Covered Individual (or the Covered Individual's guardian or estate) agrees to execute and deliver all instruments and papers (including, but not limited to, the execution of a subrogation form) and do whatever else is necessary to protect this Plan's subrogation rights.

In the event a Covered Individual (or a Covered Individual's guardian or estate) recovers or is reimbursed by any third party or insurance coverage, the Covered Individual (or the Covered Individual's guardian or estate) agrees to hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition.

The Covered Individual (or the Covered Individual's guardian or estate) agrees that he or she will make a decision on pursuing any and all claims against third parties and insurance coverage within thirty (30) days of the date of the accident or occurrence which led to the injury or condition for which Plan benefits are sought, and within said thirty (30) days period will notify the Plan in writing. In the event the Covered Individual (or the Covered Individual's guardian or estate) decides not to pursue any claims against third parties or insurance coverage, or fails to notify the Plan within thirty (30) days of said accident or occurrence of his or her intent to do so, the Covered Individual (or the Covered Individual's guardian or estate) authorizes and assigns all rights to the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims, and agrees to fully cooperate with the Plan in the prosecution of any such claims. This provision imposes no obligation on the Plan to pursue the assigned rights, nor contribute any funds toward expenses of litigation.

This Plan's right of recovery will apply whether or not payment has been made by a third party or any insurance coverage for all of the Covered Individual's losses.

If a third party or any insurance coverage makes payment before this Plan, no benefits will be paid under this Plan to the extent of the payment.

COBRA-TYPE CONTINUATION OPTIONS

PLEASE NOTE: Church Plans have been exempted from the requirement of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). However, General Synod, Associate Reformed Presbyterian Church will generally comply with the content and requirements of the law. The provisions apply to events occurring on or after January 1, 1991. While not exhaustive, the following list reflects differences between the General Synod Plan and plans not exempted from COBRA:

- (i) In Section "What is a Qualifying Event": Since some ministers have elected not to participate in Social Security and may not become eligible for Medicare, a "Qualifying Event" will occur when a retired Employee not eligible for Medicare reaches the Medicare eligibility age.
- (ii) In Section "When may a Qualified Beneficiary's COBRA-type continuation coverage be terminated":
 - (a) In Sub-Section (iv): Coverage will terminate if the Qualified Beneficiary becomes eligible as an employee or dependent, after the date of the election, under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
 - (b) In Sub-section(v): If the Qualified Beneficiary has retired and is not eligible for Medicare, coverage will end the date the Qualified Beneficiary first attains the Medicare eligibility age.
- (iii) In Section "What is Timely Payment for payment for COBRA-type continuation coverage":
 - (a) Paragraph 1: The definition of "Timely Payment" is limited to payment that is made to the Plan by the date that is 30 days after the first day of that period. Payments postmarked within the 30 day grace period will be considered timely.
 - (b) Paragraph 2: Although Qualified Beneficiaries have 60 days to enroll for continuation coverage, they will not be enrolled until they have paid the premiums due for the period from termination to and including the month of enrollment. Example: An employee terminates August 20 and has coverage to August 31. The employee must enroll no later than October 30. If the employee enrolls during September, the September premiums must be paid with enrollment. If enrollment is in October, both the September and October premiums must be paid with enrollment.

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA-type continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA-type continuation coverage? COBRA-type continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA-type continuation coverage, whichever occurs first. The right to COBRA-type continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated nonCOBRA-type beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA-type continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

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

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA-type continuation coverage) must be offered the opportunity to make an independent election to receive COBRA-type continuation coverage.

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

- (i) The death of a covered Employee.
- (ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's enrollment in the Medicare program.
- (v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.
- (vii) For those retiring on or after August 1, 2002, retiree's entitlement to Medicare (Part A or B). If the Employee has opted out of Social Security, this will be the Medicare entitlement age.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of

coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA-type if all the other conditions of the COBRA-type law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA-type continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA-type continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA-type continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA-type continuation coverage upon the timely election of such coverage. An election of COBRA-type continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA-type continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA-type continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

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

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

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA-type continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.
- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA-type continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA-type continuation coverage during which the child was born or placed for adoption.

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

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA-type maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

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

Can a Plan require payment for COBRA-type continuation coverage? Yes. For any period of COBRA-type continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA-type continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA-type continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA-type continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA-type continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated nonCOBRA-type beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA-type continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA-type continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan required to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA-type continuation coverage? If a Qualified Beneficiary's COBRA-type continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated nonCOBRA-type beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Failure to Notify Plan Administrator of Other Coverage. Should a Plan Participant become entitled to coverage under another group health plan, or entitled to benefits under Medicare, and subsequently fails to notify the Plan Administrator within fifteen (15) days of the date he/she first becomes entitled to other coverage after the date of COBRA-type election (the "Notification Period"), the Plan expressly reserves the right to retroactively cancel COBRA-type coverage and seek reimbursement of all benefits paid after the date of expiration of the Notification Period. The Plan shall refund any COBRA-type premiums remitted, less any claims paid, subsequent to the date of expiration of the Notification Period.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

General Synod, Associate Reformed Presbyterian Church (the "Plan Sponsor") sponsors the General Synod, Associate Reformed Presbyterian Church Dental Benefit Plan (the "Plan"). Members of the Plan Sponsor's workforce have access to the individually identifiable health information of the Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information ("PHI").

HIPAA and its implementing regulations restrict the Plan Sponsor's ability to use and disclose PHI. The following definition of PHI applies to this Plan Document:

Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as Permitted under this Plan Document or as otherwise required or permitted by HIPAA.

PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

I Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is currently enrolled in or has disenrolled from the Plan.

II Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

"Summary Health Information" means: information that (a) summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

III Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

The Plan will use and may disclose PHI to the Plan Sponsor named herein for the purpose of carrying out certain administrative functions related to health care treatment, payment for health care services and health care operations.

Payment includes activities undertaken by the Plan (a) to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan; or (b) to obtain or provide reimbursement for the provision of health care. In all cases, the activities must relate to the individual to whom health care is provided and expressly include, but are not limited to the following:

- A** Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims (including appeals and other payment disputes);
- B** Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- C** Billing, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance), claims management and related health care data processing (including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments);
- D** Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- E** Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
- F** Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premium or reimbursement:
 - (i)** Name and address;
 - (ii)** Date of birth;
 - (iii)** Social security number;
 - (iv)** Payment history;
 - (v)** Account number; and
 - (vi)** Name and address of the health care provider and/or health plan.

Health Care Operations include but are not limited to, the following activities:

- A** Conducting quality assessment and improvement activities;
- B** Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives and related functions that do not include treatment;
- C** Reviewing the competence or qualifications of health care professionals, and evaluating practitioner and provider performance, including accreditation, certification, licensing, or credentialing activities;
- D** Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- E** Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- F** Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
- G** Business management and general administrative activities of the Plan, including, but not limited to:
 - (i)** Management activities relating to the implementation of and compliance with the administrative simplification requirements of HIPAA;
 - (ii)** Resolution of internal grievances;
 - (iii)** Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" as that term is defined in HIPAA, or following completion of a sale or transfer, will become a covered entity.

IV Certification of Amendment to Summary Plan Description by Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Document has been amended to incorporate the following specific provisions.

The Plan Sponsor hereby agrees to:

- A** Not use or further disclose PHI other than as permitted or required by law;

- B** Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- C** Not use or disclose PHI for employment-related actions and decisions or in connection with any other employee benefit plan of the Plan Sponsor;
- D** Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- E** Make PHI available to plan participants to comply with HIPAA's right of access in accordance with 45 CFR § 164.524;
- F** Make PHI available to a plan participants, consider their amendments and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;
- G** Make available the information required to provide an accounting of PHI disclosures in accordance with 45 CFR § 164.528;
- H** Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- I** If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- J** Ensure that adequate separation between the Plans and the Plan Sponsor (i.e. the "firewall"), required in 45 CFR § 504(f)(2)(iii), is established, maintained and otherwise satisfied.

V Adequate Separation between Plan and Plan Sponsor

- A** The Plan may only disclose or otherwise provide access to PHI to the Plan Administrator and to the following employees or classes of employees of the Plan Sponsor:

Designated employees responsible for administration of the Plan.

- B** The Plan Sponsor shall restrict access to and use of PHI by the Plan Administrator and the employees or classes of employees described in Section V(A) above to the plan administration functions that the Plan Sponsor performs for the Plan.
- C** To the extent that the Plan Administrator and the employees or classes of employees described in Section V(A) above fail to comply with the provisions of this Amendment to Summary Plan Description, the plan Sponsor shall provide a mechanism for resolving any issues of noncompliance, including appropriate disciplinary measures.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR.

General Synod, Associate Reformed Presbyterian Church Employee Dental Benefit Plan is the benefit plan of General Synod, Associate Reformed Presbyterian Church, the Plan Sponsor. The Insurance Committee of the Board of Benefits of the Associate Reformed Presbyterian Church has been appointed by General Synod, Associate Reformed Presbyterian Church to be Plan Administrator to serve at the convenience of the Employer. General Synod, Associate Reformed Presbyterian Church appoints the members of the Board of Benefits.

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, to decide disputes which may arise relative to a Plan Participant'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.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant'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 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.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

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 Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

PLEASE NOTE: Church Plans have been exempted from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). However, the General Synod, Associate Reformed Presbyterian Church has chosen to provide certain benefits required by other Employers to include the right to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan.

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

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan on the rules governing COBRA-type continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA-type continuation coverage, when COBRA-type continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has 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.

GENERAL PLAN INFORMATION

COMPLIANCE WITH FEDERAL LAW. The terms of this Plan will be construed and administered to meet the minimum requirements of applicable federal laws, including the Americans with Disabilities Act of 1990 (ADA), the Family and Medical Leave Act of 1993 (FMLA), the Uniformed Services Employment and Reemployment Rights Act of 1994 (Veterans Reemployment Act), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Mental Health Parity Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998. To the extent a Plan provision is contrary to or fails to address the minimum requirements of an applicable federal law, this Plan shall provide the coverage or benefit necessary to comply with such minimum requirements.

TYPE OF ADMINISTRATION. The Plan is a self-funded plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

General Synod, Associate Reformed Presbyterian Church Dental Benefits Plan

GROUP NUMBER: GAR0801

PLAN NUMBER: 501

TAX ID NUMBER: 57-6030380

PLAN EFFECTIVE DATE: August 1, 2004

PLAN YEAR ENDS: July 31

EMPLOYER INFORMATION (PLAN SPONSOR)

General Synod, Associate Reformed Presbyterian Church
One Cleveland Street
Greenville, SC 29601
(864) 232-8297

PLAN ADMINISTRATOR

Insurance Committee, Board of Benefits
General Synod, Associate Reformed Presbyterian Church
One Cleveland Street
Greenville, SC 29601
(864) 232-8297

CLAIMS ADMINISTRATOR

Kanawha HealthCare Solutions, Inc.
P.O. Box 1000
Lancaster, South Carolina 29721
1-800-822-1274

BY THIS AGREEMENT, General Synod, Associate Reformed Presbyterian Church Dental Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for General Synod, Associate Reformed Presbyterian Church, on or as of the day and year first below written.

By: Frank E. Hogan _____
General Synod, Associate Reformed Presbyterian Church

Date: July 8, 2004

Witness: Beth Willis _____

Date: July 8, 2004