EMPLOYEE DENTAL PLAN

ADMINISTERED BY

INSURANCE SYSTEMS, INC.

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INTRODUCTION

This document, effective January 1, 2010, is a description of Vantage Health Plan, Inc. Employee Dental Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to provide Plan Participants a basic oral hygiene plan with standard coverage for certain dental expenses.

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

The 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, exclusions, timeliness of COBRA elections, 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. An expense for a service or supply is incurred on the date the service or supply is furnished. No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

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.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

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.

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

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY FOR DENTAL COVERAGE

Employee Coverage

Eligible Employees

To be eligible for *employee* coverage you must be an active *full-time employee.* And you must belong to a class of *employees* covered by the Plan*.*

Other Conditions

If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this:

(a) more than 31 days after you first become eligible; or

(b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant. If you initially waived dental coverage under the Plan because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under the Plan*,* the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events:

- (a) termination of your spouse's employment;
- (b) loss of eligibility under your spouse's *plan;*
- (c) divorce;
- (d) death of your spouse; or
- (e) termination of the other *plan.*

But you must enroll in the dental coverage under the Plan within 30 days of the date that any of the events described above occur.

Group Enrollment Period

A group enrollment period is held each year from December 1st to December 31st. During this period, you may elect to enroll in dental plan under the Plan*.* Coverage starts on the January 1st that next follows the group enrollment period. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date. But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your plan is scheduled to start, we will postpone your coverage until the date you return to active *full-time* work. Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

When Your Coverage Ends

Your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment. Your coverage ends on the date you die. It also ends on the date you stop being a member of a class of *employees* eligible for coverage under the Plan*,* or when the Plan ends for all *employees.* And it ends when the Plan is changed so that benefits for the class of *employees* to which you belong ends. If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons. Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

Employee Coverage (Cont.)

Continuation During a Family Leave of Absence

This section may not apply to the *employer's plan.* You must contact your *employer* to find out if: the *employer* must allow for a leave of absence under Federal Law, in which case; the section applies to you. Group coverage may end for you because you cease *full-time* work due to an approved leave of absence. Such leave of absence must have been granted to allow you to care for a seriously ill spouse, child or parent, or after the birth or adoption of a child, or due to your own serious health condition. If so, your group coverage will be continued. You will be required to pay the same share of the premium as before the leave of absence. Coverage may continue until the earliest of:

(a) the date you return to *full-time* work;
(b) the end of a total leave period of 12 weeks in any 12 month period;
(c) the date on which your coverage would have ended had you not been on leave; or
(d) the end of the period for which the premium has been paid.

Penalty for Late Entrants

We won't cover charges incurred by a late entrant for:

(1) Group II services until 6 months from the date he is insured by the Plan*;*
(2) Group III services until 12 months from the date he is insured by the Plan*;* and
(3) *orthodontic treatment* done in the first 24 months he is insured by the Plan*.*

However, this limitation will not apply to covered charges due solely to an *injury* suffered while insured. Charges not covered due to this provision are not considered covered dental services and cannot be used to satisfy the Plan*'s* deductibles. A late entrant is a person who:

(1) becomes insured more than 31 days after he is eligible; or
(2) becomes insured again, after his coverage lapsed because he did not make required payments

Dependent Coverage

Eligible Dependents for Dependent Dental Benefits

An *employee's eligible dependents* are:

(a) his legal spouse;
(b) his unmarried dependent children who are under age 21;
(c) his unmarried dependent children, from age 21 until their 26th birthday, who are enrolled as full-time students at accredited schools or meet the following requirement:

if the child's failure to maintain full-time status is due to a medically necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is medically necessary, coverage may continue for up to a year after the date the medically necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the medically necessary leave of absence. This extension of coverage continues to apply if the manner of providing coverage under the Plan changes (such as from self-funded to fully insured) if the changed coverage continues to provide coverage for dependent children. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

Except for a student who is on a medically necessary leave of absence, full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

Dependent Coverage (Cont.)

(d) his unmarried dependent grandchildren who are under age 21, who are in the legal custody of and residing with the *employee;* and
(e) his unmarried dependent grandchildren, from age 21 until their 26th birthday, who are enrolled as full-time students at accredited schools and are in the legal custody of and residing with the *employee.*

Adopted Children and Step-Children

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by the Plan as an *employee.* And we exclude any dependent who is on active duty in any armed force.

Handicapped Children

You may have an unmarried child or grandchild with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the Plan, such a child may stay eligible for dependent benefits past this coverage's age limit. The dependent child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if:
(a) his or her conditions started before he or she reached this coverage's age limit;
(b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and
(c) he or she depends on you for most of his or her support and maintenance.

With respect to a grandchild, the grandchild must also remain in the custody of and reside with you in order to stay eligible. But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this.

We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year. The child's coverage ends when yours does.

Waiver of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under the Plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under the Plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events:
(a) termination of your spouse's employment;
(b) loss of eligibility under your spouse's plan;
(c) divorce; (d) death of your spouse; or
(e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under the Plan within 30 days of the date that any of the events described above occur. In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if:
(a) you are under legal obligation to provide dental coverage due to a court-order; and
(b) you enroll them in the dental coverage under the Plan within 30 days of the issuance of the court-order.

Dependent Coverage (Cont.)

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of the Plan*,* the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments. If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage. If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage. If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage. If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

Exception

If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth if:

(a) you are already covered for dependent coverage when the child is born; or
(b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born.

If you fail to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form. We also cover your newborn grandchild for dependent benefits from the moment of birth, if the child is in the legal custody of and residing with you.

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided:

(a) the group coverage remains in force;
(b) the dependents remain *eligible dependents;* and
(c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under the Plan*'s* "Federal Continuation Rights" provision, or under any other continuation provision of the Plan*,* if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the

Dependent Coverage (Cont.)

continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when the Plan ends, or when dependent coverage is dropped from the Plan for all *employees* or for an *employee's* class. If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child, step-child or grandchild at 12:01 a.m. on the date he or she attains this coverage's age limit or when he or she marries. A step-child's coverage also ends when he or she is no longer dependent on you for support and maintenance. A grandchild's coverage also ends when he or she is no longer in the custody of or residing with you. And a spouse's coverage ends when a marriage ends in legal divorce or annulment. Read the Plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Coverage the Plan features which people most often want to know about. But it's not a complete description of your Dental Expense Coverage. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

Benefit Year Cash Deductible for Non-Orthodontic Services

For Group I Services	None
For Group II and III Services	$50.00 for each covered person

Payment Rates:

Benefits for covered charges are based and paid according to the geographic area's usual, reasonable and customary charges (URC). Payment rates are as follows:

For Group I Services	100%
For Group II Services	80%
For Group III Services	50%
For Group IV Services	50%

Benefit Year Payment Limit for Non-Orthodontic Services

For Group I, II and III Services	Up to $1,500.00

Lifetime Payment Limit for Orthodontic Treatment

For Group IV Services	Up to $1,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

DENTAL EXPENSE PLAN

This plan will pay many of your and your covered dependents' dental expenses. What we pay and the terms for payment are explained below.

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services. By reasonable, we mean the charge is the *dentist's* usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists.* But, in no event will the covered charge be greater than the 90th percentile of the HIAA Prevailing Fee (as determined twice yearly), or a similar standard, for a particular service in a geographic area. When routinely associated procedures are performed on the same day, the covered charge will be for the most comprehensive procedure. We only pay for covered charges incurred by a *covered person* while he's insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is prepared. A covered charge for any other *prosthetic device* is incurred on the date the master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the active *appliance* is first placed. All other covered charges are incurred on the date the services are furnished.

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit will be based on a removable partial denture.

Proof of Claim

In order to accurately pay for and determine covered charges, it is required that information acceptable to The Guardian be provided. This information shall consist of x-rays, study models, narratives or other diagnostic materials. If the necessary information is not provided, no benefit or minimum benefits may be allowable. However, if accepted necessary information is provided later, benefits will be re-determined based on the new information.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the *covered person's dentist* must send us a treatment plan before he starts. This must be done on a form acceptable to The Guardian. The treatment plan must include:

(a) a list of the services to be done, using the American Dental Association Nomenclature and codes;
(b) the itemized cost of each service; and
(c) the estimated length of treatment. Dental X-rays, study models and whatever else we need to evaluate the treatment plan must be sent to us, too.

A treatment plan must always be sent to us before *orthodontic treatment* starts. We review the treatment plan and estimate what we will pay. The estimate will be sent to the *covered person's dentist.* If we don't agree with a treatment plan, or if one is not sent in, we have the right to base our payments on treatment suited to the *covered person's* condition by accepted standards of dental practice. Pre-treatment review is not a guarantee of what we will pay. It tells the *covered person* and his *dentist,* in advance, what we would pay for the covered dental services named in the treatment plan. But payment is conditioned on:

(a) the work being done as proposed and while the *covered person* is insured; and
(b) the deductible and payment limit provisions and all of the other terms of the Plan.

Emergency treatment, oral examinations, dental X-rays and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made. We won't deny benefits if pre-treatment review is not done. But, what we pay will be based on the availability and submission of *proof* of claim.

Benefits from Other Sources

The Plan supplements the medical plan provided by your *employer,* if any. The Plan*,* and your *employer's* medical plan, if any, may provide benefits for the same charges. If they do, we subtract what your *employer's* medical plan, if any, pays from what we'd otherwise pay. Other plans may furnish similar benefits, too. For instance, you may be covered by the Plan and a similar plan through your spouse's *employer.* If you are, we coordinate our benefits with the benefits from these other plans. We do this so no one gets more in benefits than the charges he incurs. Read "Coordination of Benefits" to see how this works.

The Benefit Provision - Qualifying for Benefits

Group I, II and III - Non-Orthodontic Services

There is no deductible for Group I services. We pay for Group I services at the applicable payment rate. A *benefit year* deductible of $50.00 applies to Group II and III services. Each *benefit year,* each *covered person* must have covered charges from groups II and III which exceed this deductible before we pay him or her benefits for such charges. These charges must be incurred while he or she is insured. Once a *covered person* meets this deductible, we pay for his or her Group II and III covered charges above that amount at the applicable payment rates for the rest of that *benefit year.* All charges must be incurred while the *covered person* is insured. We limit what we pay each *benefit year* to $1,500.00. What we pay is based on all of the terms of the Plan*.*

Group IV – Orthodontic Services

The Plan provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the active *appliance* is first placed. We pay for Group IV covered charges at the applicable payment rate. Using the treatment plan, we calculate the total benefit we will pay. We divide this into equal payments, which we spread out over the shorter of two years or the proposed length of treatment. We make the initial payment when the active *appliance* is first placed. We make further payments as billed, but no more than once per month. But treatment must continue and the *covered person* must stay insured. And we limit what we pay during a covered person's lifetime to $1,000.00. What we pay is based on all of the terms of the Plan*.* Orthodontic benefits won't be charged against the *benefit year* payment limit which applies to all other services.

Non-Orthodontic Family Deductible Limit

No family must meet more than three *benefit year* deductibles in any *benefit year.* Once this happens, we pay for *covered charges* incurred by any covered person, at the applicable payment rate, for the rest of that *benefit year.* But the charges must be incurred while insured. And what we pay is subject to the *benefit year* payment limit and to all of the other terms of the Plan*.*

Payment Rates

Benefits for covered charges are paid at the following rates:

Benefits for Group I Services are paid at a rate of	100%
Benefits for Group II Services are paid at a rate of	80%
Benefits for Group III Services are paid at a rate of	50%
Benefits for Group IV Services are paid at a rate of	50%

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows: If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year,* receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold,* he or she may be entitled to a Reward. *Rewards* can accrue and are stored in the *covered person's Bank.* If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank.* The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum* A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason. The amounts of the Plan*'s Rollover Threshold, Reward,* and *Bank Maximum* are:

Rollover Threshold	$700.00
Reward	$350.00
Bank Maximum	$1,250.00

If the Plan*'s* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year.* And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year.* In either case: only claims incurred on or after January 1 will count toward the *Rollover Threshold;* and *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies. If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of the Plan called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of the Plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and: only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold;* and *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward* .
"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank.*
"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold.*
"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward.*

After This Plan Ends

We won't pay for charges incurred after this plan ends. But we pay for the following if all work is finished in the 31 days after this plan ends:

(a) a crown, bridge or cast restoration, if the tooth is prepared before the plan ends;
(b) any other *prosthetic device,* if the master impression is made before the plan ends; and
(c) root canal treatment, if the pulp chamber is opened before the plan ends.

Benefits for *orthodontic treatment* will only be paid to the end of the month in which the plan ends. The final payment will be pro-rated.

Special Limitations

Teeth Lost or Missing Before a Covered Person Becomes Insured by the Plan

A *covered person* may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by the Plan. We won't pay for a *prosthetic device* which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the *covered person* became insured by the Plan.

If the Plan Replaces another Plan

The Plan may be replacing another plan your *employer* had with some other insurer. We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before the Plan starts, if:

(1) the *covered person* was insured by the old *plan;* and
(2) the old *plan* would have paid for such charges.

But the Plan must start right after the old *plan* ends. And the covered person must be insured by the Plan from the start. We limit what we pay to the lesser of:

(1) what the old *plan* would have paid; or
(2) what we would otherwise pay.

And we deduct any benefits actually paid by the old *plan* under any extension provision. In the first *benefit year* of the Plan*,* we also reduce the Plan*'s* deductibles by the amount of covered charges applied against the old *plan's* deductible. And, in the first *benefit year,* we charge benefits which were paid by the old *plan* against the Plan*'s* payment limits.

Exclusions

We won't pay for:
- Oral hygiene, plaque control or diet instruction.
- Precision attachments.
- Desensitizing medicaments.
- Prescription medication.
- Treatment which does not meet accepted standards of dental practice.
- Treatment which is experimental in nature.

We won't pay for any *appliance* or *prosthetic device* used to:
- Change vertical dimension.
- Restore or maintain occlusion, except to the extent that the Plan covers *orthodontic treatment.*
- Splint or stabilize teeth for periodontal reasons.
- Replace tooth structure lost as a result of abrasion or attrition.

We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to:
- Characterizing and personalizing *prosthetic devices.*
- Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.

We won't pay for replacing an *appliance* or *prosthetic device* or processed veneer with a like appliance or device, unless:
- It is at least ten years old and can't be made usable.
- It is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.

We won't pay for any service, appliance, device or modality intended to treat disturbances of the temporo-mandibular joint.

We won't pay for:
- Replacing a lost, stolen or missing *appliance* or *prosthetic device.*

Exclusions (Cont.)

- Making a spare *appliance* or device.
- Implants.
- Tooth transplants,
- Surgical repositioning of the jaw.
- Overdentures

We won't pay for treatment needed due to:
- An on-the-job or job-related injury.
- A condition for which benefits are payable by Worker's Compensation or similar laws.

We won't pay for treatment for which no charge is made. This usually means treatment furnished by:
- The *covered person's employer,* labor union or similar group, in its dental or medical department or clinic.
- A facility owned or run by any governmental body.
- Any public program, except Medicaid, paid for or sponsored by any government body.

But if a charge is made and we are legally required to pay it, we will.

List of Covered Dental Services

The services covered by the Plan are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services. All covered dental services must be furnished by or under the direct supervision of a *dentist.* And they must be usual and necessary treatment for a dental condition.

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis and Fluoride Treatments
Prophylaxis, including periodontal prophylaxis (Topical application of fluoride is limited to *covered persons* under age 14 and limited to one treatment in any six consecutive month period) - Allowance includes examination, scaling and polishing.

Office Visits and Examinations
Initial or periodic oral examination (limited to one examination in any 6 consecutive month period).
- Emergency palliative treatment and other non-routine, unscheduled visits.

Space Maintainers (Limited to covered persons under age 16 and limited to initial appliance only) Allowance includes all adjustments in the first six months after installation:
- Fixed, unilateral, band or stainless steel crown type.
- Fixed, unilateral, cast type.
- Removal, bilateral type.

Fixed and Removable Appliances
To Inhibit Thumb sucking - (limited to covered persons under age 14 and limited to initial appliance only) - Allowance includes all adjustments in the first 6 months after installation.

Diagnostic Services
Allowance includes examination and diagnosis.
- X-Rays
- Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 60 consecutive month period).
- Bitewing films (limited to a maximum of four films in one visit, in any 12 consecutive month period).
- Other intraoral periapical or occlusal films - single films (limited to 4 periapical & 2 occlusal in any 12 consecutive month period).

Group I - Preventive Dental Services (Cont.)
(Non-Orthodontic)

Extraoral superior or inferior maxillary film (limited to 2 in any 12 consecutive month period).
- Panoramic film, maxilla and mandible (only for treatment of accidents, cysts & tumors).

Dental Sealants Posterior Teeth
- Topical application of sealant (limited to the unrestored permanent molar teeth of *covered persons* under age 16 and limited to one treatment per tooth in any 36 consecutive month period).

Group II - Basic Dental Services
(Non-Orthodontic)

Office Visits and Examinations
Diagnostic consultation with a dentist other than the one providing treatment (limited to one consultation for each dental specialty in any 12 consecutive month period) - We pay for this only if no other service is rendered during the visit.

Diagnostic Services
Allowance includes examinations and diagnosis.
- Diagnostic casts - complex restorative cases only.
- Biopsy and examination of oral tissue.

Restorative Services Multiple restorations on one surface will be considered one restoration. Also see "Major Restorative Services".
- Amalgam restorations.
- Synthetic restorations: Silicate cement, Acrylic or plastic, and Composite resin.
- Crowns: Stainless steel.
- Pins: Pin retention, exclusive of restorative material.

Endodontic Services
Allowance includes routine X-Rays and cultures, but excludes final restoration.
- Pulp capping, direct.
- Remineralization (Calcium Hydroxide), as a separate procedure.
- Vital pulpotomy.
- Apexification.
- Root canal therapy on non-vital (nerve-dead) teeth: Traditional therapy, and Medicated paste therapy, N2 Sargenti.
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures.

Periodontal Services
Allowance includes the treatment plan, local anesthetics and post-surgical care.
- Gingivectomy or gingivoplasty, per quadrant (limited to once in 36 months on a given area.)
- Gingivectomy, per tooth (fewer than 6 teeth).
- Sub-gingival curettage and root planing, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).
- Pedicle or free soft tissue grafts, including donor sites.
- Osseous surgery, including flap entry and closure, per quadrant (once every 3 years).
- Osseous grafts, including flap entry, closure and donor sites.
- Muco-gingival surgery.
- Occlusal adjustment, not involving restorations and done in conjunction with periodontal surgery, per quadrant (limited to a maximum of 4 quadrants in any 36 consecutive month period).

Oral Surgery
Allowance includes routine X-Rays, the treatment plan, local anesthetics and post-surgical care.
- Extractions
- Uncomplicated non-surgical extraction, one or more teeth.
- Surgical removal of erupted teeth, involving tissue flap and bone removal.

Group II - Basic Dental Services (Cont.)

- Surgical removal of impacted teeth.

Other Surgical Procedures
- Alveolectomy, per quadrant.
- Stomatoplasty with ridge extension, per arch.
- Removal of mandibular tori, per quadrant.
- Excision of hyperplastic tissue.
- Excision of pericoronal gingival, per tooth.
- Removal of palatal torus.
- Removal of cyst or tumor.
- Incision and drainage of abscess.
- Closure of oral fistula or maxillary sinus.
- Reimplantation of tooth.
- Frenectomy.
- Suture of soft tissue injury.
- Sialolithotomy for removal of salivary calculus.
- Closure of salivary fistula.
- Dilation of salivary duct.
- Sequestrectomy for osteomyelitis or bone abscess, superficial.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.

Prosthodontic Services
Specialized techniques and characterization are not covered. Also see "Major Prosthodontic Services".
- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns - allowance based on the extent and nature of damage and the type of material involved.

Other Services - General anesthesia in connection with surgical procedures only.
- Injectable antibiotics needed solely for treatment of a dental condition.

Group III - Major Dental Services
(Non-Orthodontic)

Restorative Services
Cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material. Also see "Basic Restorative Services".
- Inlays
- Onlays, in addition to inlay allowance.
- Crowns and Posts
- Acrylic with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- 3/4 cast metal (other than stainless steel).
- Cast post and core, in addition to crown (not a thimble coping).
- Steel post and composite or amalgam core, in addition to crown.
- Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.
- Acrylic or plastic, without metal
- Crown buildup.
- Labial veneers.
- Recementation
- Inlay or onlay.
- Crown.
- Bridge.

Group III - Major Dental Services (Cont.)

Prosthodontic Service
Specialized technique and characterizations are not covered.
- Fixed bridges - Each abutment and each pontic makes up a unit in a bridge.
- Bridge abutments - See inlays and crowns under "Major Restorative Services".
- Bridge Pontics
- Cast metal, sanitary.
- Plastic or porcelain with metal.
- Slotted facing.
- Slotted pontic.
- Simple stress breakers, per unit.
- Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.
- Dentures - Allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation.
- Full dentures, upper or lower.
- Partial dentures - Allowance includes base, all clasps, rests and teeth.
- Upper, with two chrome clasps with rests, acrylic base.
- Upper, with chrome palatal bar and clasps, acrylic base.
- Lower, with two chrome clasps with rests, acrylic base.
- Lower, with chrome lingual bar and clasps, acrylic base.
- Stayplate base, upper or lower (anterior teeth only).
- Denture repairs, acrylic
- Repairing dentures, no teeth damaged.
- Repairing dentures and replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.
- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.
- Denture duplication, jump case (limited to once per denture in any 60 consecutive month period).
- Denture reline (limited to once per denture in any 24 consecutive month period):
- Office reline.
- Laboratory reline.
- Denture adjustments (limited to adjustments made by a dentist other than the one providing the denture, and adjustments are more than 6 months after the initial installation).
- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 24 consecutive month period).
- Repairs to bridges - allowance based on the extent and nature of damage and the type of materials involved).

<u>Group IV - Orthodontic Services</u>

Orthodontic Services
- Any Group I, II or III service in connection with *orthodontic treatment.*
- Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes routine x-rays, local anesthetics and post-surgical care.
- Active *appliances* - All types - Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active *appliance,* and all related office visits including post-treatment stabilization.

COORDINATION OF BENEFITS

Important Notice
This provision applies to all dental expense benefits under the Plan. It does not apply to death, dismemberment, or loss of income benefits.

Purpose of this Provision
An employee may be covered for dental expense benefits by more than one plan. For instance, he may be covered by the Plan as an employee and by another plan as a dependent of his spouse. If he is, this provision allows us to coordinate what we pay with what another plan pays. We do this so the covered person doesn't collect more in benefits than he incurs in charges.

Definitions
"We" and "our" mean Vantage Health Plan, Inc. Employee Dental Plan.

"Plan" means any of the following that provides dental expense benefits or services:

(A) group, blanket, or franchise plans;
(B) group Blue Cross plans, group Blue Shield plans, group HMOs or other service or prepayment plans on a group basis;
(C) union welfare plans, employer plan, employee benefits plans, trustee labor and management plans, or other plans for members of a group;
(D) programs or coverages required or provided by law, including Medicare or other governmental benefits;

"Plan" does not include coverage under individual or family policies or contracts, school accident-type coverages, Medicaid or any other government program or coverage which we are not allowed to coordinate with by law.

"The Plan" means the part of our group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for dental expense benefits.

"Dependent" means a person who is covered by a plan for dental expense benefits, but not as a member.

"Allowable expense" means any needed, reasonable, and usual expense for dental care incurred by a member or dependent under the Plan and at least one other plan. When a plan provides service instead of cash payment, we view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view benefits payable by another plan as an allowable expense and as a benefit paid, whether or not a claim is filed under that plan.

"Claim determination period" means a calendar year in which a member or dependent is covered by the Plan and at least one other plan and incurs one or more allowable expense under such plans.

How this Provision Works
We apply this provision when a member or dependent is covered by more than one plan. When this happens we consider each plan separately when coordinating payments. In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision. If a plan has no coordination provision, it is primary. But, during any claim determination period, when the Plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

(A) A plan that covers a person as a member pays first; the plan that covers a person as a dependent pays second; except that, if the person is also a Medicare beneficiary, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent.

Coordination of Benefits (Cont.)

(B) A plan that covers a person as an active employee or as a dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second. But, if the plan that we're coordinating with does not have a similar provision for such persons, then (B) will not apply.

(C) A plan that covers a person as an active employee or as a dependent of such employee pays first. A plan that covers a person or that person's dependent under a right of continuation pursuant to federal or state law pays second. But, if the plan that we're coordinating with doesn't have a similar provision for such persons, then (C) will not apply.

(D) Except for dependent children of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member: A plan that covers a dependent of a member whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of a member whose birthday falls later in the calendar year pays second. Except that if both members have the same birthday, the plan which has covered a member for the longer time pays first. The member's year of birth is ignored. But, if the plan that we're coordinating with does not have a similar provision for such persons, then (D) will not apply and the other plan's coordination provision will determine the order of benefits.

(E) For a dependent child of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member:

(1) When a court order makes one parent financially responsible for the dental care expenses of the dependent child, then that parent's plan pays first.

(2) If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody;

(3) The plan of the stepparent with custody pays before the plan of the natural parent without custody.

(4) If a court order states that both parents have joint custody of the child without stating that one of the parents is responsible for the dental care expenses of the dependent child, then benefits will be determined by Rule (D) above. If rules (A), (B), (C), (D) and (E) don't determine which plan pays first, the plan that has covered the person for the longer time pays first. If, when we apply this provision, we pay less than we would otherwise pay, we apply only that reduced amount against payment limits of the Plan.

Our Right to Certain Information

In order to coordinate benefits, we need certain information. An employee must supply us with as much of that information from any source. And if another insurer needs information to apply its coordination provision, we have the right to give that insurer such information. If we give or get information under this section we can't be held liable for such action. When payments that should have been made by the Plan have been made by another plan, we have the right to repay that plan. If we do so, we're no longer liable for that amount. And if we pay out more than we should have, we have the right to recover the excess payment.

Small Claims Waiver

We don't coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 we'll count the entire amount of the claim when we coordinate.

YOUR CONTINUATION RIGHTS

Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under the Plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If your group dental benefits under the Plan would otherwise end because you enter into active military service, the Plan will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group dental benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of the Plan. Coverage under the Plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Vantage Health Plan, Inc. Employee Dental Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of dental coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. The Plan Administrator is Vantage Health Plan, Inc., 130 DeSiard Street, Suite 300, Monroe, Louisiana, 71201, (318) 361-0900. COBRA continuation coverage for the Plan is administered by Insurance Systems, Inc., P.O. Box 2175, Monroe, Louisiana 71207, (318) 322-6774. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?

COBRA continuation coverage is the temporary extension of group dental plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

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

Continuation Coverage Rights Under COBRA (Cont.)

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) 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). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions. An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary. Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event?

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

(1) The death of a covered Employee.

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

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

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

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

(6) 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.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (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 if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage. The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee

Continuation Coverage Rights Under COBRA (Cont.)

does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.)

Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage?

You should take into account that a failure to continue your group dental coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group dental plans if there is more than a 63-day gap in dental coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual dental insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group dental plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage?

The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited. Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group dental plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information. The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified dental insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Continuation Coverage Rights Under COBRA (Cont.)

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,
(2) death of the employee,
(3) commencement of a proceeding in bankruptcy with respect to the employer, or
(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

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

NOTICE PROCEDURES:

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

Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201

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

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

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**. Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension. Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Continuation Coverage Rights Under COBRA (Cont.)

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

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

Is COBRA coverage available if a Qualified Beneficiary has other group dental plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group dental plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group dental plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated?

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

(1) The last day of the applicable maximum coverage period.
(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
(3) The date upon which the Employer ceases to provide any group dental plan (including a successor plan) to any employee.
(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the qualified Beneficiary.
(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim. In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Continuation Coverage Rights Under COBRA (Cont.)

What are the maximum coverage periods for COBRA continuation coverage?

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

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

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

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

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

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

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

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

Under what circumstances can the maximum coverage period be expanded?

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

How does a Qualified Beneficiary become entitled to a disability extension?

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

Does the Plan require payment for COBRA continuation coverage?

For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension.

Continuation Coverage Rights Under COBRA (Cont.)

The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?

Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period. Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan. If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion dental plan at the end of the maximum coverage period for COBRA continuation coverage?

If a Qualified Beneficiary's COBRA continuation coverage under a group dental plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion dental plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group dental plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

Vantage Health Plan, Inc. Employee Dental Plan is the benefit plan of Vantage Health Plan, Inc., the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Vantage Health Plan, Inc. to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Vantage Health Plan, Inc. shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.
(2) To 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 Processor to pay claims.
(7) To perform all necessary reporting as required by ERISA.
(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION.

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

FIDUCIARY

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

FIDUCIARY DUTIES

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

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

Fiduciary Duties (Cont.)

THE NAMED FIDUCIARY

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

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA. **CLAIMS PROCESSOR IS NOT A FIDUCIARY.** A Claims Processor 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.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below). Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and dental care operations. The terms "payment" and "dental care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for dental care. "Dental care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of dental care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.
(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
    (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
    (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
    (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the

Compliance with HIPAA Privacy Standards (Cont.)

Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

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

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

Human Resources Manager, Chief Executive Officer and Chief Financial Officer.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

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

Compliance with HIPAA Electronic Security Standards (Cont.)

Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

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

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

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 Processor.

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.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination. The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain 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.

Certain Plan Participant's Rights under ERISA (Cont.)

Continue dental 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 or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group dental 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 dental plan or dental insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA 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.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court. In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded group dental Plan and the administration is provided through a Third Party Claims Processor. 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
Vantage Health Plan, Inc. Employee Dental Plan

PLAN NUMBER: 501

TAX ID NUMBER: 72-1285173

PLAN EFFECTIVE DATE: January 1, 2010

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201
(318) 361-0900

PLAN ADMINISTRATOR
Director of Operations
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201
(318) 361-0900

NAMED FIDUCIARY
Director of Operations
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201

AGENT FOR SERVICE OF LEGAL PROCESS
Director of Operations
Vantage Health Plan, Inc.
130 DeSiard Street, Suite 300
Monroe, Louisiana 71201

CLAIMS PROCESSOR
Insurance Systems, Inc.
P.O. Box 2175
Monroe, Louisiana 71207
(318) 322-6774