SUMMARY PLAN DESCRIPTION

for the

SOUTHEASTERN FREIGHT LINES
DENTAL COMPONENT PLAN

October 1, 2024

THIS SUMMARY PLAN DESCRIPTION IS NOT A CONTRACT, EITHER EXPRESS OR IMPLIED.

TABLE OF CONTENTS

I. Introduction

This Summary Plan Description ("SPD") is designed to describe the dental coverage provisions (the "Group Dental Coverage") of the Southeastern Freight Lines, Inc. Health Insurance Plan (the "Plan of Benefits") in effect on October 1, 2024, pursuant to which a dental coverage option is offered through your employment as a full-time associate of Southeastern Freight Lines, Inc. (the "Employer"). The Plan of Benefits is a component plan benefit under the Southeastern Freight Lines, Inc. Insurance Plan (the "Insurance Plan"). The terms of this SPD are incorporated into and should be read in conjunction with the Insurance Plan, which contains many of the governing provisions. This SPD is intended to summarize the Insurance Plan rules applicable only to Group Dental Coverage.

This SPD supersedes and replaces all prior SPDs for dental coverage provided under the Plan of Benefits. The Group Dental Coverage provided under the Plan of Benefits is referred to in this SPD as such or as the Employer's Group Health Plan. In the event there is a conflict between this SPD and the Plan of Benefits, the Plan of Benefits will control. Delta Dental of Missouri ("DDMO" or "Corporation") provides claim administration services with respect to the Group Dental Coverage, but does not insure the benefits described. This is in no way a contract or promise of continued employment with the company.

II. Explanation and Definitions of Terms

Throughout this SPD certain terms starting with capital letters are used to explain the benefits under this Plan of Benefits. Unless the context dictates otherwise, use of the male pronoun in this booklet will be deemed to include the female. To help you better understand the benefits most of these terms are defined within the text or in this Definitions section.

Alternate Recipient: Any Child who is recognized under a Medical Child Support Order as having a right to enroll for Group Dental Coverage.

Associate: A person who is employed by the Employer.

Benefit Year: The Benefit Year for the Group Dental Coverage is January 1 through December 31.

Benefit Year Deductible: The amount, if any, listed on the Schedule of Benefits that must be paid by the Member each Benefit Year before the Group Health Plans will pay Covered Expenses. The Benefit Year Deductible is subtracted from the Allowable Charge before Coinsurance is calculated. Members must refer to the Schedule of Benefits to determine if the Benefit Year Deductible applies to the Out-of-Pocket Maximum.

COBRA: Those provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, P.L. 99-272, as amended, and Sections 601 through 608 of ERISA, as amended, and Section 4980B of the IRC, as amended, and Sections 2201 through 2208 of the Public Health Service Act, as amended, which require certain employers to offer continuation of health care coverage to Associates and Dependents of Associates who would otherwise lose coverage. The COBRA provisions applicable to the Plan of Benefits are discussed in the Insurance Plan.

Coinsurance: The sharing of Covered Expenses between the Member and the Plan of Benefits. After the Member's Benefit Year Deductible requirement is met, the Plan of Benefits will pay the percentage of Allowable Charges as set forth on the Schedule of Benefits. The Member is responsible for the remaining percentage of the Allowable Charge. Coinsurance is calculated after any applicable Benefit Year Deductible or Copayment is subtracted from the Allowable Charge based upon the network charge or the lesser charge of the Provider.

Employer: Southeastern Freight Lines, Inc.

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

Family: Any coverage tier that covers more than one member.

Group Health Plan: An employee welfare benefit plan to the extent that such plan provides health benefits to employees or their dependents, as defined under the terms of such group health plan, directly or through insurance, reimbursement, or otherwise. The Plan of Benefits is a Group Health Plan.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, and any amendments and regulations thereto.

Medical Child Support Order: Any judgment, decree or order (including an approved settlement agreement) issued by a court of competent jurisdiction or a national medical support notice issued by the applicable state agency which:

- Provides child support with respect to a Child or provides for health benefit coverage to a Child, is made pursuant to a state domestic relations law (including a community property law), and relates to the Plan of Benefits;
- Enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a Group Health Plan.

A Medical Child Support Order must clearly specify:

1. The name and the last known mailing address (if any) of each Member and the name and mailing address of each Alternate Recipient covered by the order; and,
2. A reasonable description of the type of coverage to be provided by the Group Health Plan to each such Alternate Recipient or the manner in which such type of coverage is to be determined; and,
3. The period to which such order applies; and,
4. Each Group Health Plan to which such order applies.

If the Medical Child Support Order is a national medical support notice, the order must also include:

1. The name of the issuing agency; and,
2. The name and mailing address of an official or agency that has been substituted for the mailing address of any Alternate Recipient; and,
3. The identification of the underlying Medical Child Support Order.

A Medical Child Support Order meets the requirement of this definition only if such order does not require a group health plan to provide any type or form of the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993).

Member: An Associate or Eligible Dependent, as defined in the Insurance Plan, who has enrolled for Group Dental Coverage under this Plan of Benefits. These are also known as "Covered Members."

Member Effective Date: The date on which an Associate or Eligible Dependent is covered for Benefits, as described in the Insurance Plan.

Non-PPO Participating Dentist (Delta Dental Premier Network): Delta Dental's Premier network consists of dentists who have agreed to accept payment based on the lesser of filed fees or the applicable Premier Maximum Plan Allowance.

Non-Participating Dentist: If you go to a non-participating dentist (not contracted with a Delta Dental plan), DDMO will make payment directly to you based on the lesser of the dentist's billed charge or the applicable Maximum Plan Allowance. It will be your obligation to make full payment to the dentist and file your own claim.

PHI: Protected Health Information as that term is defined under HIPAA.

Plan Administrator: The Employer, who is charged with the administration of the Plan of Benefits.

Plan of Benefits: The Southeastern Freight Lines, Inc. Health Insurance Plan.

Plan Year: The term "Plan Year" means each twelve-month period, which begins on January 1 and ends on December 31.

PPO Participating Dentist (Delta Dental PPO Network): Delta Dental's PPO network consists of dentists who have agreed to accept payment based on the lesser of usual fees or the applicable PPO Maximum Plan Allowance and to abide by Delta Dental policies.

Premium: The amount paid to the Employer by the Member for Group Dental Coverage under this Plan of Benefits. Payment of Premiums by the Member constitutes acceptance by the Member of the terms of the Plan of Benefits and this SPD.

Qualified Medical Child Support Order: A Medical Child Support Order that:

1. Creates or recognizes the existence of an Alternate Recipient's right to enroll under this Plan of Benefits; or,
2. Assigns to an Alternate Recipient the right to enroll under this Plan of Benefits.

Spouse: A person who has entered into a ceremonially solemnized legal marriage with the covered Associate and is recognized as the spouse under the Internal Revenue Code. "Spouse" shall also include a person treated as a Spouse of a covered Associate under the terms of the Southeastern Freight Lines, Inc. Health Insurance Plan in effect on December 31, 2003. The Plan Administrator may require documentation proving a legal marital relationship.

You and Your: The terms "you" and "your" mean the Associate.

III. Premiums

The Premium schedule will be established annually by the Employer and communicated to you as part of the annual Open Enrollment materials. Failure to pay any Premium when due may result in termination of your elected Group Dental Coverage.

IV. Disclosure of Medical Information

By accepting Benefits or payment of Covered Expenses, the Member agrees that the Employer's Group Health Plan (including Delta Dental of Missouri or "DDMO," the claims administrator on behalf of the Employer's Group Health Plan) may obtain claims information, medical records, and other information necessary for the Employer's Group Health Plan to consider a request for predetermination or to process a claim for Benefits.

V. Dental Benefits Available

A. Selection of a Dentist

You may visit the dentist of your choice and select any dentist on a treatment by treatment basis. It is important to remember your out-of-pocket costs may vary depending on your choice. You have three options: PPO Participating Dentist (Delta Dental PPO Network), Non-PPO Participating Dentist (Delta Dental Premier Network), and Non-Participating Dentist.

There are advantages to selecting a participating dentist. All participating dentists (PPO and Premier) have the necessary forms needed to submit your claim. Delta Dental participating dentists will usually file your claims for you and DDMO will pay them directly for covered services. Visit the DDMO website (www.deltadentalmo.com) to find out if your dentist participates or contact DDMO to receive, at no cost, a list of participating PPO and Premier dentists in your area. You are not responsible for paying the participating dentist any amount that exceeds the PPO or Premier Maximum Plan

Allowance, whichever is applicable. You are only responsible for any non-covered charges, deductible, and coinsurance amounts.

B. Maximum Plan Allowance

The term "Maximum Plan Allowance" means the amount determined by the Plan Administrator/DDMO as the highest amount allowed for a particular procedure, service, or item for the particular dentist or service provider. The amount allowed for a particular dentist or service provider depends on its, his or her participation status (e.g.: PPO Participating Dentist, Premier Dentist or Non-Participating Dentist).

C. Schedule of Benefits

Your schedule of benefits included in this booklet will show which of the four types of coverage listed below are included in your dental program. It will also show the amount of your deductible and which levels of coverage the deductible applies to.

After you satisfy your dental deductible (if it applies), your dental benefits will pay a specific percentage of the Maximum Plan Allowance, up to your benefit maximum each benefit period. You will be responsible for the remaining amount.

Coverage Levels:	A, B, C & D
Benefit Year Deductible:	$50 per person
Applies to:	B, C, & D coverage
Family Limit:	$150

Co-Insurance

Coverage A:	100%
Coverage B:	80%
Coverage C:	60%
Coverage D:	60%

Benefit Maximum

Coverages A, B, and C (if applicable):	$2,500 (annually)
Coverage D:	$2,500 (lifetime)

Dependent Child Age Limit:	To age 26

Your orthodontic benefits are subject to lifetime maximum for these benefits, as well as to the annual benefit maximum.

Your dental benefits are provided according to a calendar benefit period, which begins on January 1 of each year. The calendar year benefit period begins on the Effective Date and ends on December 31 in which the Effective Date occurs. A new calendar year benefit period begins each year on January 1.

VI. Coverage Available

I. Coverage A: Preventive Services --- Covered to the extent shown on the Schedule of Benefits:

- oral examinations (evaluations), twice in any benefit period (includes all types);
- bitewing and periapical x-rays as required;
- full mouth x-rays, shall include either a complete mouth series or a panoramic x-ray, once in any 36 month period;
- dental prophylaxis (cleaning, scaling, and polishing including periodontal maintenance visits), twice in any benefit period;
- topical fluoride application for Eligible Dependent Children under age 19 twice in any benefit period;
- emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain);
- space maintainers that replace prematurely lost teeth of Eligible Dependent Children under age 16 (once in five years), except for accidental injuries.

II. Coverage B: Basic Service --- Covered to the extent shown on the Schedule of Benefits:

- restorative services using amalgam, synthetic porcelain and plastic filling material;
- periodontics: treatment for diseases of the gums and bone supporting the teeth; periodontal surgery is covered only once in a 3 year period for the same site; coverage for scaling and root planing are limited to once per 24 months;
- endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth);
- simple and surgical extractions;
- sealants: This coverage is available only for Eligible Dependent Children under the age of 19, limited to caries-free occlusal surfaces of the first and second permanent molars (once in 5 years);
- general anesthesia in conjunction with covered surgical procedures.

III. Coverage C: Major Services --- Covered to the extent shown on the Schedule of Benefits:

- prosthetics: bridges and dentures, once in 5 years;
- crowns, jackets, labial veneers, and onlays when required for restorative purposes, and when teeth cannot be restored with a filling material, once in 5 years;
- oral surgery (except for extractions under coverage B);
- Implants as well as bone grafts, are limited to once in 5 years per tooth.

IV. Coverage D: Orthodontic Services --- Covered to the extent shown on the Schedule of Benefits:

- Orthodontic care: treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position. This coverage is available only for Eligible Dependent Children under age 19 and does not apply to covered Associates or Spouses of covered Associates.

VII. Coverage Limitations

- Multiple individual x-rays provided on the same date of service will be considered a complete mouth series if the total allowed amount equals or exceeds the allowed amount for a complete mouth series.
- Endodontic (root canal treatment) on the same tooth is covered only once in a 2-year period. Re-treatment of the same tooth is allowed when performed by a different dental office.
- Charges for replacement of filling restorations are only covered once in a 24-month period, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.
- If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in 5 years, but not during the first year of Coverage C benefits.
- Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay or onlay on or for a

particular tooth will only be provided once in 5 years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.

- If your coverage is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the date of termination.
- Benefits will not be paid for repair or replacement of an orthodontic appliance.
- After completion of your orthodontic treatment plan or reaching your orthodontic lifetime maximum, no further orthodontic benefits will be provided.
- If you receive care from more than one dentist or service provider for the same procedure, benefits will not exceed what would have been paid to one dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy).
- If alternative treatments are available, DDMO will be liable for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the allowed amount for an amalgam (silver) filling; or services such as fixed bridges, in which case the benefits may be based on the allowed amount for a removable partial denture.

VIII. Dental Services Not Covered

Charges for the following are not covered:

- Services or supplies for which you, absent this coverage, would normally incur no charge, such as care rendered by a dentist to a member of his immediate family or the immediate family of his spouse.
- Services or supplies for which coverage is available under workers' compensation or employers' liability laws.
- Services or supplies performed for cosmetic purposes or to correct congenital malformations, except newborns with congenital dental defects.
- Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws) that are covered by Part II of this booklet.
- Services or supplies not specifically stated as covered dental services (including hospital or prescription drug charges).
- Replacement of dentures and other dental appliances which are lost or stolen.
- Diseases contracted or injuries or conditions sustained as a result of any act of war.
- Denture adjustments for the first six months after the dentures are initially received. Separate fees may not be charged by participating dentists.
- Complete occlusal adjustments, crowns for occlusal correction, athletic mouthguards, nightguards, bruxism appliances, and bite therapy appliances.
- Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of the complete dental procedure. These services are considered components of, and included in, the fee for the complete procedure. Separate fees may not be charged by participating dentists.
- Analgesia, including Nitrous Oxide, duplication of radiographs, temporary appliances, or implants and related procedures.
- Services or supplies rendered by a dental or medical department maintained by or on behalf of a employer, a mutual benefit association, union, trustee or similar person or group.
- Services or supplies provided or paid for by or under any governmental agency or program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act, as amended). This exclusion applies to the extent that benefits are provided or would have been provided had the participant enrolled, applied, or maintained eligibility for such benefits under any such law.
- Services rendered beyond the scope of a dentist's or service provider's license, or experimental or investigational services/supplies.
- Services or supplies that a dentist determines for any reason, in his professional judgment, should not be provided.
- Instructions in dental hygiene, dietary planning, or plaque control.
- Missed appointments or claim form completion.

- Infection control, including sterilization of supplies and equipment.
- Hypnosis
- Duplicate services provided by another group dental plan.
- Charges for experimental or investigational services or supplies.
- Injuries to sound natural teeth that are covered by Group Medical Coverage under the Plan of Benefits.

IX. Claim Filing Procedures

Your claims must be filed by the end of the calendar year following the year in which services were rendered. The Plan of Benefits is not obligated to pay claims submitted after this period. If a claim is denied due to a PPO or Premier participating dentist's failure to make timely submission, you will not be liable to such dentist for the amount which would have been payable by the Plan of Benefits, provided you advised the dentist of your eligibility for benefits at the time of treatment.

Claims should be filed at the following address:

Delta Dental of Missouri
P.O. Box 8690
St. Louis, Missouri 63126-0690

X. Explanation of Benefits

In certain circumstances, when a claim is filed, by you or a dentist, you will receive a form called an Explanation of Benefits ("EOB") from us. It tells you what services were covered and what, if any, were not. An explanation of how to appeal a claim is on the front of the EOB as well as in this SPD.

XI. Appeal Procedures

You will be provided written notice if your claim for benefits under the Plan of Benefits has been denied, setting forth the specific reasons for such denial, written in a manner to be understood by you. Additionally, if your claim for benefits has been denied, you will be afforded a reasonable opportunity for full review of the decision denying the claim, including appeals and requests for review.

Within 180 days after receiving the denial, you may submit a written request for reconsideration of the claim to the Appeals Committee for DDMO. Any such request should be accompanied by documents or records in support of the appeal. You may review pertinent documents relating to the claim and submit issues and comments in writing for consideration by the Appeals Committee. The Committee will review your appeal and will notify you in writing of the decision within 60 days after your appeal is received.

In the case of an appeal involving medical judgment, DDMO will consult with a health care professional who has training and experience in the field involved in the medical judgment. The consultant will be an individual who is neither an individual who was consulted in connection with the initial denial, nor the subordinate of any such individual. DDMO will identify the consultant whose advice was obtained on behalf of the Plan of Benefits, without regard to whether the advice was relied upon in making the benefit determination.

Any request for reconsideration should be sent to: Delta Dental of Missouri

Appeals Committee
12399 Gravois Rd.
St. Louis, Missouri 63127-1702

XII. Coordination of Benefits

If you have other dental coverage, benefits under this program are coordinated with benefits under any such other program to avoid duplication of payment. The two programs together will not pay more than 100% of covered expenses. The Plan of Benefits may recover benefit overpayments.

XIII. Claim Predetermination

If the care you need costs less than $200 or is emergency care, your dentist will proceed with treatment at your option. If the cost estimate is more than $200 and is not emergency care, your dentist will determine what treatment you need and could submit a treatment plan to DDMO for predetermination of benefits. This estimate will enable you to determine in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

XIV. Limitation on Assignments

A Member's rights and benefits under this Plan of Benefits cannot be assigned, sold, or transferred to any person, including a healthcare provider or other creditor, without the express written consent of the Plan Administrator, except as permitted by a Qualified Medical Child Support Order. This means that a Member may not assign a right to receive benefit payments. At its option, the Plan Administrator may direct the Corporation to make payments directly to a healthcare provider, but a direct payment to a healthcare provider shall not constitute an assignment of health benefits or rights under the Plan of Benefits. This also means that a Member may not assign a right to dispute coverage, to appeal an adverse benefit determination, or to maintain any other ERISA action with respect to this Plan of Benefits. Any purported assignment of benefits or rights under the Plan of Benefits made without the express written consent of the Plan Administrator shall be void and shall not apply to the Plan of Benefits. The Plan Administrator's or the Corporation's direct payment to a healthcare provider or direct communication with a healthcare provider regarding this Plan of Benefits shall not constitute consent to an assignment or a waiver of this limitation.

XV. Workers' Compensation Provision

The Plan of Benefits does not provide benefits for diagnosis, treatment or other service for any injury or illness that is sustained or alleged by a Member that arises out of, in connection with, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required or is otherwise available for the Member. Benefits will not be provided under the Plan of Benefits if coverage under the Workers' Compensation Act or similar law would have been available to the Member but the Member or the Employer elected exemption from available workers' compensation coverage; waived entitlement to workers' compensation benefits for which he/she is eligible; failed to timely file a claim for workers' compensation benefits; or, the Member sought treatment for the injury or illness from a Provider not authorized by the Member's Employer or Workers' Compensation carrier.

Although treatment for work-related or alleged work-related injuries or illness is excluded under the Plan of Benefits, the Plan Administrator may, in its sole discretion, agree to extend Benefits to a Member for the injury or illness. In this instance, the Member agrees, as a condition of receiving Benefits, to reimburse the Plan of Benefits in full from any workers' compensation recovery as described herein. The Member further agrees as a condition of receiving Benefits, to execute and deliver all required instruments and papers provided by the Plan Administrator/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan of Benefits' right of recovery, before any medical or other Benefits will be paid by the Plan of Benefits for the injuries or illness. The Plan Administrator may determine, in its sole discretion, that it is in the Plan of Benefits' best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan of Benefits will remain entitled to reimbursement from any workers' compensation recovery the Member may receive.

As a condition of receiving Benefits, the Member must:

- Immediately notify the Plan Administrator/Corporation of an injury or illness for which his/her employer and/or Employers' Workers' Compensation carrier may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
- Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;

- Deliver to the Plan Administrator/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injury or illness within ninety (90) days of being requested to do so;
- Assert a claim or lawsuit against the Employer and/or Employer's Workers' Compensation carrier or any other insurance coverage to which the Member may be entitled;
- Include the Benefits paid by the Plan of Benefits as a part of the damages sought against his/her employer and/or employer's Workers' Compensation carrier. Immediately reimburse the Plan of Benefits, out of any recovery made from the employer and/or employer's Workers' Compensation carrier, the amount of medical or other Benefits paid for the injuries or illness by the Plan of Benefits up to the amount of the recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
- Immediately notify the Plan Administrator/Corporation in writing of any proposed settlement and obtain the Plan Administrator/Corporation's written consent before signing any release or agreeing to any settlement; and,
- Cooperate fully with the Plan Administrator/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Corporation.

The Plan Administrator/Corporation has sole discretion to determine whether claims for Benefits submitted to the Plan of Benefits are related to the injuries or illness to the extent this provision applies. If the Plan Administrator/Corporation pays Benefits for an injury or illness and the Plan Administrator/Corporation determines the Member also received a recovery from the Employer and/or Employer's Workers' Compensation carrier by means of a settlement, judgment, or other payment for the same injury or illness, the Member shall reimburse the Plan of Benefits from the recovery for all Benefits paid by the Plan of Benefits relating to the injury or illness. However, under no circumstances shall the Member's reimbursement to the Plan of Benefits exceed the amount of such recovery.

If the Member receives a recovery from the employer and/or employer's Workers' Compensation carrier, the Plan of Benefits' right of reimbursement from the recovery will be applied even if: liability is denied, disputed, or is made by means of a compromised, doubtful and disputed, clincher or other settlement; no final determination is made that the injury or illness was sustained in the course of or resulted from the Member's employment; the amount of workers' compensation benefits due to medical or health care is not agreed upon or defined by the Member, employer or the Workers' Compensation carrier; or, the medical or health care benefits are specifically excluded from the settlement or compromise.

Failure to reimburse the Plan of Benefits from the recovery as required under this section will entitle the Plan Administrator/Corporation to invoke the Workers' Compensation exclusion and deny payment for all claims relating to the injury or illness.

XVI. Subrogation and Reimbursement

A. Benefits Subject To This Provision

This provision shall apply to all Benefits provided under any section of the Plan of Benefits. All Benefits under this Plan of Benefits are being provided by a self-funded ERISA plan.

B. Statement of Purpose

Subrogation and Reimbursement represent significant assets and are vital to the financial stability of the Plan of Benefits. Subrogation and Reimbursement recoveries are used to pay future claims by other covered Members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan of Benefits. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these assets of the Plan of Benefits to the fullest extent possible. By accepting Benefits related to an injury or illness under this Plan of Benefits, a Member agrees to the terms and conditions provided herein.

C. Definitions

Another Party:
Another Party shall mean any individual or entity, other than the Plan of Benefits, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Member's injuries or illness.

Another Party shall include the party or parties who caused the injuries or illness; the liability insurer, guarantor or other indemnifier of the party or parties who caused the injuries or illness; a Member's own insurance coverage, such as uninsured, underinsured, medical payments, no fault, homeowner's, renter's or any other insurer; a workers' compensation insurer or governmental entity; or, any other individual, corporation, association or entity that is liable or legally responsible for payment in connection with the injuries or illness.

Member:
As it relates to the Subrogation and Reimbursement Provision, a Member shall mean any person, Dependent or representatives, other than the Plan of Benefits, who is bound by the terms of the Subrogation and Reimbursement Provision herein. A Member shall include but is not limited to any beneficiary, Dependent, spouse or person who has or will receive Benefits under the Plan of Benefits, and any legal or personal representatives of that person, including parents, guardians, attorneys, trustees, administrators or executors of an estate of a Member, and heirs of the estate.

Recovery:
Recovery shall mean any and all monies identified, paid or payable to the Member through or from Another Party by way of judgment, award, settlement, covenant, release or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the injuries or illness. A Recovery exists as soon as any fund is identified as payable for a Member from Another Party. Any recovery shall be deemed to apply, first, for Reimbursement of the Plan of Benefits' lien. The amount owed from the Recovery as Reimbursement of the Plan of Benefits' lien is an asset of the Plan of Benefits.

Reimbursement:
Reimbursement shall mean repayment to the Plan of Benefits of recovered medical or other Benefits that it has paid toward care and treatment of the injuries or illness for which there has been a Recovery.

Subrogation:
Subrogation shall mean the Plan of Benefits' right to pursue the Member's claims for medical or other charges paid by the Plan of Benefits against Another Party.

D. When this Provision Applies

This provision applies when a Member incurs medical or other charges related to injuries or illness caused in part or in whole by the act or omission of the Member or another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the injuries or illness; or Another Party may otherwise make a payment without an admission of liability. If so, the Member may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Member agrees, as a condition of receiving Benefits from the Plan of Benefits, to transfer to the Plan of Benefits all rights to recover damages in full for such Benefits.

E. Duties of the Member

The Member will execute and deliver all required instruments and papers provided by the Plan Administrator/Corporation, including an accident questionnaire, as well as doing and providing whatever else is needed, to secure the Plan of Benefits' rights of Subrogation and Reimbursement, before any medical or other Benefits will be paid by the Plan of Benefits for the injuries or illness. The Plan

Administrator/Corporation may determine, in its sole discretion, that it is in the Plan of Benefits' best interests to pay medical or other Benefits for the injuries or illness before these papers are signed (for example, to obtain a prompt payment discount); however, in that event, the Plan of Benefits will remain entitled to Subrogation and Reimbursement. In addition, the Member will do nothing to prejudice the Plan of Benefits' right to Subrogation and Reimbursement and acknowledges that the Plan of Benefits precludes operation of the double-recovery, made whole and common fund doctrines. A Member who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan of Benefits' lien to the Plan of Benefits under the terms of this provision. A Member who receives any such Recovery and does not immediately tender the Plan of Benefits' portion of the Recovery to the Plan of Benefits will be deemed to hold the Plan of Benefits' portion of the Recovery in constructive trust for the Plan of Benefits, because the Member is not the rightful owner of the Plan of Benefits' portion of the Recovery and should not be in possession of the Recovery until the Plan of Benefits has been fully reimbursed. The portion of the Recovery owed by the Member for the Plan of Benefits' lien is an asset of the Plan of Benefits.

As a condition of receiving Benefits, the Member must:

1. Immediately notify the Plan Administrator/Corporation of an injury or illness for which Another Party may be liable, legally responsible, or otherwise makes a payment in connection with the injuries or illness;
2. Execute and deliver an accident questionnaire within one hundred eighty (180) days of the accident questionnaire being mailed to the Member;
3. Deliver to the Plan Administrator/Corporation a copy of the Personal Injury Protection Log, Medical Payments log and/or Medical Authorization within ninety (90) days of being requested to do so;
4. Deliver to the Plan Administrator/Corporation a copy of the police report, incident or accident report, or any other reports issued as a result of the injuries or illness within ninety (90) days of being requested to do so;
5. Authorize the Plan Administrator to sue, compromise and settle in the Member's name to the extent of the amount of medical or other Benefits paid for the injuries or illness under the Plan of Benefits and the expenses incurred by the Plan Administrator in collecting this amount, and assign to the Employer's Group Health Plan the Member's rights to Recovery when this provision applies;
6. Include the Benefits paid by the Plan of Benefits as a part of the damages sought against Another Party. Immediately reimburse the Plan of Benefits, out of any Recovery made from Another Party, the amount of medical or other Benefits paid for the injuries or illness by the Plan of Benefits up to the amount of the Recovery and without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise;
7. Immediately notify the Plan Administrator/Corporation in writing of any proposed settlement and obtain the Plan Administrator/Corporation's written consent before agreeing to any settlement;
8. Immediately notify the Plan Administrator/Corporation in writing of any proposed release of Another Party and obtain the Plan Administrator/Corporation's written consent before releasing Another Party; and,
9. Cooperate fully with the Plan Administrator/Corporation in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan Administrator/Corporation.

F. First Priority Right of Subrogation and/or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. The Employer's Group Health Plan of Benefits will be subrogated to all rights the Member may have against that other person or Another Party and will be entitled to first priority Reimbursement out of any Recovery to the extent of the Plan of Benefits' payments. In addition, by accepting Benefits under this Plan of Benefits, a Member acknowledges and agrees that the Employer's Group Health Plan has established a first priority equitable lien against any Recovery to the extent of Benefits paid and to be payable in the future. The Plan of

Benefits' first priority equitable lien supersedes any right that the Member may have to be "made whole." In other words, the Employer's Group Health Plan is entitled to the right of first Reimbursement out of any Recovery the Member procures or may be entitled to procure regardless of whether the Member has received full compensation for any of his or her damages or expenses, including attorneys' fees or costs and regardless of whether the Recovery is designated as payment for medical expenses or otherwise, and regardless of whether the Member is not fully compensated or made whole for his or her loss. Additionally, the Plan of Benefits' right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative or contributory negligence, limits of collectability or responsibility, characterization of Recovery as pain and suffering or otherwise. The Employer's Group Health Plan may enforce its right to Reimbursement by filing a lawsuit, recouping the amount owed from a Member's future benefit payments (regardless of whether benefits have been assigned by a Member to a hospital or other medical provider), and any other remedy available under the Plan of Benefits. As a condition to receiving Benefits under the Plan of Benefits, the Member agrees that acceptance of Benefits is constructive notice of this provision.

G. When a Member Retains an Attorney

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) for an injury or illness in which the Plan of Benefits has paid or will pay Benefits, has an absolute obligation to immediately tender the portion of the Recovery subject to the Plan of Benefits' equitable lien to the Employer's Group Health Plan under the terms of this provision. As a possessor of a portion of the Recovery, the Member's attorney holds the Recovery as a constructive trustee and fiduciary and is obligated to tender the Plan of Benefits' portion of the Recovery immediately over to the Plan of Benefits. A Member's attorney who receives any such Recovery and does not immediately tender the Plan of Benefits' portion of the Recovery to the Employer's Group Health Plan will be deemed to hold the Recovery in constructive trust for the Plan of Benefits, because neither the Member nor the attorney is the rightful owner of the portion of the Recovery subject to the Plan of Benefits' lien. The portion of the Recovery owed for the Plan of Benefits' lien is an asset of the Plan of Benefits.

If the Member retains an attorney, the Member must immediately notify the attorney of the existence of an equitable lien under this provision. The Member's attorney must recognize and consent to the fact that this provision precludes the operation of the "made-whole," "common fund," and "double recovery" doctrines, and the attorney must agree not to assert those doctrines against the Employer's Group Health Plan in his or her pursuit of Recovery. The Employer's Group Health Plan will not pay the Member's attorneys' fees and costs associated with the recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Member's attorneys' fees and costs, without the expressed written consent of the Corporation.

H. When the Member is a Minor or is Deceased or Incapacitated

This Subrogation and Reimbursement Provision will apply with equal force to the parents, trustees, guardians, administrators, or other representatives of a minor, incapacitated, or deceased Member and to the heirs or personal and legal representatives, regardless of applicable law. No representative of a Member listed herein may allow proceeds from a Recovery to be allocated in a way that reduces or minimizes the Plan of Benefits' claim by arranging for others to receive proceeds of any judgment, award, settlement, covenant, release or other payment or releasing any claim in whole or in part without full compensation therefore or without the prior written consent from the Plan Administrator/Corporation.

I. When a Member Does Not Comply

When a Member does not comply with the provisions of this section, the Plan Administrator/Corporation shall have the authority, in its sole discretion, to deny payment of any claims for Benefits by the Member and to deny or reduce future Benefits payable (including payment of future Benefits for other injuries or illnesses) under the Plan of Benefits by the amount due as satisfaction for

the Reimbursement to the Plan of Benefits. The Plan Administrator/Corporation may also, in its sole discretion, deny or reduce future Benefits (including future Benefits for other injuries or illnesses) for the Member under any other group benefits plan maintained by the Employer. The reductions will equal the amount of the required Reimbursement; however, under no circumstances shall the Reimbursement, denial or reduction of Benefits exceed the amount of the Recovery. If the Plan Administrator must bring an action against a Member to enforce the provisions of this section, then the Member agrees to pay the Plan of Benefits' attorneys' fees and costs, regardless of the action's outcome.

J. Prior Recoveries

In certain circumstances, a Member may receive a Recovery that exceeds the amount of the Plan of Benefits' payments for past and/or present expenses for treatment of the injuries or illness that is the subject of the Recovery. In other situations, based on the extent of the Member's injuries or illness, the Member may have received a prior Recovery for treatment of the injuries or illness that is the subject of a claim for Benefits under the Plan of Benefits. In these situations, the Plan of Benefits will not provide Benefits for any expenses related to the injuries or illness for which compensation was provided through a current or previous Recovery. The Member is required to submit full and complete documentation of any such Recovery in order for the Plan Administrator to consider eligible expenses. To the extent a Member's Recovery exceeds the amount of the Plan of Benefits' lien, the Plan of Benefits is entitled to deny that amount as an offset against any claims for future Benefits relating to the injuries or illness. In those situations, the Member will be solely responsible for payment of medical bills related to the injuries or illness. The Employer's Group Health Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

The Plan Administrator/Corporation has sole discretion to determine whether expenses are related to the injuries or illness to the extent this provision applies. Acceptance of Benefits under the Plan of Benefits for injuries or illness which the Member has already received a Recovery may be considered fraud, and the Member will be subject to any sanctions determined by the Plan Administrator/Corporation, in their sole discretion, to be appropriate, including denial of present or future Benefits under the Plan of Benefits.

K. Recovery of Overpayments

This Subrogation and Reimbursement Provision shall also apply in the event of any overpayment of Benefits by the Plan of Benefits. In the event of any overpayment of Benefits by the Plan of Benefits, the Employer's Group Health Plan will have the right to recover the overpayment. If a Member is paid Benefits greater than allowed in accordance with the provisions of the Plan of Benefits, the Member shall be requested to refund the overpayment. If payment is made on behalf of the Member to a hospital, doctor, or other medical care provider, and that payment is found to be an overpayment, the Plan Administrator will request a refund of the overpayment from the provider first. If the provider does not honor the Plan of Benefits' request for a refund, the Plan Administrator will then request the overpayment from the Member. If the refund is not received from the provider or the Member, the amount of the overpayment may be deducted from future benefits.