PRIDE, INC.

EMPLOYEE DENTAL BENEFIT PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

July 1, 2011
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I – ELIGIBILITY & ENROLLMENT

EMPLOYEES

A – ELIGIBILITY

A full-time Employee of the Employer who regularly works at least 35 hours per week will be eligible to participate in the Plan provided such Employee is a resident of the United States.

An Eligible Employee’s participation in the Plan is subject to a waiting period of three (3) months of continuous, full-time employment from the date such full-time employment begins.

An Employee’s Enrollment Date is the day the waiting period began or the date of the “Special Enrollment”.

An Employee’s Eligibility Date is the first of the month coincident with or next following the completion of the waiting period

B – PLAN ENROLLMENT

An Eligible Employee who elects to participate in the Plan must complete, sign and return the provided “Enrollment Form” to the Employer within (30) days of the Eligibility Date in order to receive coverage under the Plan. Failure to enroll within this time limit will be deemed “waiver of participation” and future coverage under the Plan is allowed only during “Special Enrollment Periods”.

SPECIAL ENROLLMENT PERIODS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this Plan, provided that you request enrollment within thirty (30) days after the other coverage ends. This requires either that the other coverage naturally expires or ends due to a COBRA qualifying event; not the voluntary termination of the coverage by the Employee. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption, or placement for adoption.

FAMILY DEPENDENTS

A – ELIGIBILITY

Eligible Family Dependents will be an Eligible Employee’s Spouse and each dependent child who is not yet Age 26.
Child, as used herein, shall also include stepchild, adopted child (from the date of placement with the Employee for purpose of legal adoption), a child for whom the Employee is: the legal guardian or required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). This QMCSO may also be the result of either a court order or an administrative process established under state law. However, under these circumstances the Employee must provide the Plan with proof of such adoption, dependency, guardianship or support order. The Plan has adopted procedures governing QMCSO determinations; Plan participants and beneficiaries can obtain, without charge, a copy of the procedures from the Benefit Administrator.

No individual may be covered under this Plan as both an Employee and a Dependent. If a husband and wife are both Eligible Employees under the Plan, only one of them may cover their Eligible Dependent(s). Eligible family Dependents of an Employee can be covered only if the Employee is covered, except in the case of a Qualified COBRA Continuation.

B – ELIGIBILITY CONTINUATION FOR DEPENDENT CHILDREN

MENTALLY OR PHYSICALLY DISABLED CHILD: If an unmarried dependent child, Age 26 or older, is incapacitated and unable to be self-supporting because of mental retardation or physical disability, then such child will be an Eligible Dependent.

However, the Employee must provide the Benefit Administrator with written evidence of a child’s full-time student status or incapacity status.

A Family Dependent’s Eligibility Date is the same date the Employee’s Eligibility Date or, if later, the date on which the Employee first acquires the Eligible Dependent.

C – PLAN ENROLLMENT

In order for an Eligible Family Dependent(s) to be eligible to participate in the Plan, the Eligible/Covered Employee must also complete, sign and return an “Enrollment Form” for Family Coverage to the Employer. The Eligible Family Dependent(s) may only be enrolled in the Plan under the following:

The Employee must enroll the Eligible Dependent(s) within thirty (30) days of whichever of the following occurs first:

1. the Employee’s Eligibility Date if he has an Eligible Dependent(s) at that time or
2. the date the Covered Employee first acquires an Eligible Dependent.

Failure to enroll within this time limit will be deemed “waiver of participation” and future coverage under the Plan is allowed only during “Special Enrollment Periods”.

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SPECIAL ENROLLMENT PERIODS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in this Plan, provided that you request enrollment within thirty (30) days after the other coverage ends. This requires either that the other coverage naturally expires or ends due to a COBRA qualifying event: not the voluntary termination of the coverage by the Employee. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.

A Family Dependent’s Enrollment Date is: (a) the Covered Employee’s Enrollment Date if the Covered Employee enrolls for Family coverage within thirty (30) days of the Employee’s Eligibility Date; (b) the date the Employee first acquires and enrolls the Eligible Dependent if the Employee acquires the Eligible Dependent after the Employee’s Eligibility Date; or (c) if later, any other date on which the Covered Employee first Enrolls for Family Coverage with respect to the Covered Dependent in accordance with the provisions of the Plan.

II – EFFECTIVE DATE OF COVERAGE

A – EMPLOYEES

Coverage for an Eligible Employee who enrolls in the Plan pays any applicable premium (as stated in a separate form) will be effective on:

1. for newly eligible Employees, the Employee’s Eligibility Date if he enrolls within thirty (30) days thereafter; or

2. The first day of the month following the completion of 30 days of continuous employment.

B – FAMILY DEPENDENTS

When an employee properly enrolls in Family Coverage under the Plan as previously indicated and pays any applicable premium (as stated in a separate form), a Dependent’s coverage will be effective on:

1. for Eligible Dependents of newly eligible Employees, the Employee’s effective date; or

2. for Eligible Dependents of Covered Employees, the date the Dependent was acquired; or

3. for all others, the date of the “Special Enrollment” Right.
III – TERMINATION OF GROUP COVERAGE

A – EMPLOYEE TERMINATION

Group Coverage for an Employee will terminate on whichever of the following occurs first:

1. The last date for which the Employee ceases to be in an eligible and enrolled status under the Plan.

2. The last day of the month in which the Employee terminates employment with the Employer.

3. The last date for which a contribution was properly paid when due, by the Employee, if applicable.

4. The date on which the Employee submits his written notice of coverage cancellation to the Employer.

5. The date this Plan terminated and not replaced by another plan by the Employer.

6. The date ending after a period of allowed absence under the Federal Family and Medical Leave Act of 1993, subject to the rules and provisions of the Act.

Termination of Employment will mean cessation of active work due to lay-off, approved leave-of-absence (other than #6 above), employee death, voluntary or involuntary resignation, total disability or being pensioned or retired.

However, coverage for Employees (and their eligible dependents) may be continued or frozen during Military service under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Employees should note that coverage for Employees while in the Armed Forces is limited under the Plan. (See Section VIII – Exclusions and Limitations) Please inform the Plan Administrator or Benefit Administrator of your wish to continue coverage.

B – FAMILY DEPENDENT TERMINATION

Group Coverage for a Dependent will terminate on whichever of the following occurs first:

1. The last date for which the Dependent ceases to be in an eligible and enrolled status under the Plan.

2. The last date on which the Dependent Spouse is legally separated or divorced from the Employee.

3. The date on which a Dependent Child marries.
4. The date on which a Dependent Child reaches Age 19 except as specifically provided.

5. The date a Dependent enters into Military Service.

6. The last date for which a contribution was properly paid when due, if applicable.

7. The date on which the Employee submits his written notice of Dependent Coverage cancellation to the Employer.

8. The date the Employee’s group coverage terminates for whatever reason.

9. The date this Plan is terminated and not replaced by another plan by the Employer.

IV – COBRA COVERAGE CONTINUATION PROVISIONS

QUALIFYING EVENTS

A – EMPLOYEES

If group coverage terminates for the Employee due to the Employee’s termination or reduction in hours of employment for any reason except when the Employee is terminated by the Employer for gross misconduct, the Employee qualifies for the Coverage Continuation Privilege. The Coverage Continuation Privilege is not available when the Employee voluntarily cancels coverage under the Plan.

If the Employer cancels group coverage for all employees and the Plan is replaced, the Coverage Continuation Privilege is not available and all coverage under the Coverage Continuation Privilege, which is in progress, will be canceled.

B – FAMILY DEPENDENTS

If the Dependent’s coverage under the Plan terminates due to: (1) the termination or reduction in hours of the covered Employee (except if the termination is due to the Employee’s gross misconduct); (2) the Employee’s death; (3) the Dependent’s divorce or legal separation from the Employee; (4) the Dependent’s enrollment in Medicare, or; (5) the Dependent child’s reaching an age when he is no longer eligible as a Dependent, then the Dependent may elect to have coverage continue for him under the Coverage Continuation Privilege. The Coverage Continuation Privilege is not available when the Employee is terminated by the Employer for gross misconduct or when the Employee voluntarily cancels coverage under the Plan. If the Employer cancels group coverage for all Employees and the Plan is not replaced, the Coverage Continuation Privilege is not available and all coverage under the Coverage Continuation Privilege, which is in progress, will be canceled.
COBRA COVERAGE CONTINUATION PRIVILEGE

The Employee and/or Dependent(s) who qualify may elect to continue coverage through payment of the Monthly COBRA Contribution to the Employer. The contribution is due on the first day of each month for which coverage is to be in force. However, there is a thirty (30) day Grace Period from the due date in which to submit the Monthly COBRA Contribution.

A – EMPLOYEES

Coverage continued under the Employee’s privilege for himself and/or his Dependent(s) will terminate on whichever of the following occurs first:

1. the date, after the date of the COBRA election, the Employee becomes covered under any group health plan that does not include a Pre-Existing Conditions Clause which applies to either the employee or any covered dependent;

2. the date the Employee becomes enrolled in Medicare Coverage if it occurs after the date of the COBRA election;

3. the date the Employee fails to pay, when due, the required monthly contribution to continue coverage;

4. the date eighteen (18) months have expired from the date group coverage terminated unless the Employee or any covered dependent is determined to be disabled by the Social Security Administration and to have been so at any time within the first sixty (60) days of Cobra coverage. In this case, the Employee or covered Dependent must notify the Employer in writing prior to the expiration of the initial eighteen (18) months in order to extend this continuation privilege (which includes Dependents who were covered under the Cobra Continuation Coverage) for up to an additional eleven (11) months, or until the individual is no longer disabled, whichever occurs first.

5. the date of the Employee’s death; or

6. the date this Plan is terminated and not replaced by another plan by the Employer.

The Employee has the option to continue coverage for himself and/or his Covered Family Dependent(s) or to continue coverage only for the covered individual affected by either the pre-existing conditions clause (1) or determined to be disabled (4) as indicated above.

B – FAMILY DEPENDENTS
Coverage continued under the Dependent’s privilege will terminate on whichever of the following occurs first:

1. the date, after the date of the COBRA election, the Spouse and/or Dependent Child(ren) are covered under any group health plan that does not include a Pre-Existing Conditions clause which applies to any covered dependent;

2. the date the Dependent becomes enrolled in Medicare Coverage if it occurs after the date of the COBRA election;

3. the date the Dependent fails to pay, when due, the required monthly contribution to continue coverage;

4. the date this Plan is terminated and not replaced by another plan by the Employer; or

5. the date thirty-six (36) months have expired from the date the Dependent’s group coverage terminated, provided one of the following events occurred to initiate this termination:
   a. the date the Spouse and Dependent children lose coverage due to a divorce or legal separation
   b. the date the surviving Spouse and Dependent children lose coverage due to the death of a covered Employee
   c. the date the Spouse and Dependent children lose coverage due to the covered Employee becoming enrolled in Medicare
   d. the date a Dependent Child’s coverage terminates due to a change in his eligibility status (the Dependent Child then qualifies to individually elect to continue coverage which would then be subject to termination as indicated in paragraphs 1 through 5 above).

If the Dependent is affected by more than one qualifying event, a second and separate election to continue coverage may be made. However, the Maximum Duration for any one or combination of continuation privileges cannot exceed thirty-six (36) months from the date the original event occurred, which terminated group coverage for the Dependent. Further, if any of the events occur as indicated in paragraphs 1 through 5 above, then continued coverage for the Dependent would terminate.

Note: Dependents born, adopted or placed for adoption after COBRA Coverage is elected and is in force are also eligible to be covered.

COBRA CONTINUATION PRIVILEGE TIME LIMITS

A – EMPLOYEES
The Employee and/or his Dependent(s) who qualify under the Employee’s privilege, have various time limits in which to exercise this privilege and prevent forfeiture as follows:

1. a **60-Day Time Limit** from the date he receives Employer notification of this privilege in which to make application to the Employer to continue coverage;

2. a **45-Day Time Limit** from the date he has signed and submitted his application before the initial COBRA payment is due for the coverage period which encompasses the next day following group coverage termination and up to the application date; and

3. thereafter, a **30-Day Time Limit** or Grace Period from the first of each COBRA Month in which to remit the COBRA Contribution

**B – FAMILY DEPENDENTS**

The Dependent has various time limits in which to exercise this privilege and prevent forfeiture as follows:

1. a **60-day Time Limit** from the later of: the date the Employee is Divorced, Legally Separated or enrolled in Medicare or the Dependent Child is no longer eligible as a Dependent, or the date on which the Dependent would lose coverage on account of one of these events, in which to notify the Employer that he is no longer eligible under the Plan;

2. a **60-Day Time Limit** from the date he receives the subsequent Employer notification of this privilege in which to make application to the Employer to continue coverage;

3. a **45-Day Time Limit** from the date he has signed and submitted his application before the initial COBRA payment is due for the coverage period which encompasses the next day following group coverage termination and up to the application date; and

4. thereafter, a **30-Day Time Limit** or Grace Period from the first of each COBRA Month in which to remit the COBRA Contribution.
V – SCHEDULE OF DENTAL BENEFITS

The Plan only provides benefits to **Covered Individuals**. In order to be a Covered Individual, a person must meet the Eligibility, Enrollment, and Coverage requirements of Sections I and II of the Plan and must not have his coverage terminated pursuant to Section III of the Plan, or the person must meet requirements for COBRA continuation coverage under Section IV of the Plan.

**PRE-DETERMINATION:** Any treatment plan estimated to be in excess of $300 should be reported to the Claims Administrator for review prior to treatment.

<table>
<thead>
<tr>
<th>Deductibles and Maximum's</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Lifetime Deductible Per Individual</td>
<td>$100</td>
</tr>
<tr>
<td>Plan Year Maximum Benefit</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

**Preventive Services (Deductible does not apply)**

- Dental Exams: 100%
- Cleanings: 100%
- Fluoride Treatments (for children to age 19): 90%
- X-rays: 100%
- Sealants (to age 14): 90%

**Basic Services**

- Emergency Palliative Treatment: 80% after deductible
- Fillings- amalgam, porcelain & plastic: 80% after deductible
- Extractions: 80% after deductible
- Anesthesia: 80% after deductible
- Pathology: 80% after deductible
- Caps: 80% after deductible

**Major Restorative Services** *subject to 12 month waiting period*

- Prosthetics: 50% after deductible
- Crowns & Gold Fillings, Inlays, Onlays, pontics & other eligible services: 50% after deductible

**Orthodontics**

No Coverage

Notes:

All charges are subject to Usual and Customary pricing.

*Major restorative services are eligible only after 12 months of continuous coverage on Pride Inc’s, Dental Plan.*
VI – DENTAL COVERAGE DEFINITIONS

CALENDAR YEAR: January 1 through December 31 of each year. Except for an individual’s initial participation in the Plan, then the Calendar Year will commence on the effective date of coverage and end on December 31.

DEDUCTIBLE: Is the total amount of Eligible Expenses for covered Diagnostic and Preventive Services which must be incurred by the Covered Individual per lifetime before Dental Benefits are payable for such services under the Plan.

The Deductible Carryover provides that if, during the last three months of a Calendar Year, a Covered Individual incurs Eligible Expenses which are applicable to that Calendar Year Deductible, those expenses will also be applied to the Deductible for the next succeeding Calendar Year.

DENTAL HYGIENIST: A person who is duly licensed to practice Dental Hygiene by and qualified under the laws of the State in which his services are rendered provided such hygienist works for and under the supervision and direction of a Dentist.

DENTAL SERVICE: Any Service or class of services or supply provided to a Covered Individual for the dental diagnosis, treatment or care to the extent described under this Plan.

DENTIST: Any Doctor of Medicine (MD), Dental Surgery (DDS) or Dental Medicine (DDM) and Dental Hygienists for eligible dental services, which they personally perform. The Dentist must be duly licensed and qualified under the laws of the State in which such eligible dental services are performed.

ELIGIBLE EXPENSE: A covered Dental Service to which the Usual & Customary Charge criteria is applied to determine the allowable amount before Benefits are applied and paid.

PRE-DETERMINATION: The pre-Treatment review is to determine the eligibility of the individual and the coverage for services in accordance with the Schedule of Benefits.

SINGLE PROCEDURE: A dental service to which a separate procedure code is assigned by the Plan.

TREATMENT PLAN: Is a written report showing the recommended treatment of any dental disease, defect or injury, which is prepared by a Dentist as the result of his examination of an individual while covered under this Plan.

USUAL & CUSTOMARY CHARGE: The criteria used to establish the Eligible Expense for covered dental services to which Dental Benefits are applied and paid. For any specific Dental Service, Supply or Procedure, the Provider’s usual charge for such service will be eligible for Benefits not to exceed the customary charge of most Providers in the area for a similar service or supply.

1. USUAL CHARGE: the billed charge of the Dentist (provider) who renders the specific service, supply or procedure to the Covered Individual

2. CUSTOMARY CHARGE: The normal charge of most Dentists in the area for a similar service or supply; more specifically:
a. SIMILAR SERVICE is of the same nature and duration, requires the same skill and is performed by a Provider of similar training and experience.

b. SIMILAR SUPPLY is one which is identical or substantially equivalent

c. AREA means the geographic location in which the dental service or supply is actually provided to the Covered Individual. When determining the Customary Charge, the Area used can be a municipality or, in the case of a large city, a subdivision thereof, or such greater area as determined by the Plan or its Dental Consultant(s), that is necessary for obtaining a representative cross-section of charges for a Similar Service or Supply in order to establish the Customary Charge or maximum allowable charge.

When determining the amount of Eligible Expense for a covered dental service, in addition to applying the Usual & Customary Charge criteria, further consideration is given to the nature and severity of the condition and any complications or unusual circumstances which require additional time, skill or experience.

WAITING PERIOD: Charges for major restorative care are eligible for coverage only after 12 months of continuous coverage on Pride Inc’s Dental Plan.

VII – COVERED DENTAL SERVICES

Covered Dental Services which are performed or supervised by a Dentist and provided to a Covered Individual shall be payable as indicated in the Schedule and are deemed to include:

A – PREVENTIVE & DIAGNOSTIC SERVICES (No Deductible Applies)

1. Initial, Periodic or Diagnostic Oral Examinations. Limited two during a plan year.

2. Prophylaxis, Sealants & Topical Applications. Teeth cleaning, polishing and topical fluoride treatments are limited to twice per plan year. Further, topical fluoride treatments are limited to a covered dependent child up to Age 19.

3. Radiographs/X-Rays. Routine, Full-Mouth, Cephalometric and Panoramic X-Rays are limited to once in any three-year period unless special need is shown.

4. Space Maintainers.

B – BASIC RESTORATIVE SERVICES (Deductible Applies)

1. Fillings, Inlays or Onlays.

2. Emergency Palliative Services.

3. Oral Surgery. Includes extractions and general anesthesia relative to such surgical services.

4. Endodontic Services (Root Canal Therapy).
5. Periodontic Services. Includes gingival and osseous surgery, periodontic scaling, root planing, and Osseous (Bone) Surgical Services.

C – MAJOR PROSTHETIC SERVICES (Deductible and Waiting Period Applies)

1. Crowns (not part of a Bridge).
2. Bridges, Removable or Fixed. Includes crowns, which are part of the Bridge.
3. Dentures, Full or Partial.
4. Adjustments, Repairs & Related Services for Prosthetic Devices.

VIII – EXCLUSIONS & LIMITATIONS

Covered Dental Services shall not be deemed to include any services or expense which is incurred for, caused by or results from:

1. Dental Services for which the Covered Individual incurs no charge.
2. Dental Services for which benefits are received (or could be received if a claim were made) under any Worker’s Compensation Law or similar legislation, or charges for dental treatment or services which are rendered under any municipal, county, state, federal or other governmental agency, law or regulation for which a charge is not imposed.
3. Dental Services provided primarily for cosmetic purposes except following an accidental injury that occurred while the individual was covered under this Plan and provided such services are rendered within 12 months of such injury.
4. Charges for failure to keep a scheduled dental office appointment.
5. Charges for the completion of any insurance or claim forms.
6. Prescription Drugs.
7. Services or supplies which do not meet accepted standards of dental practice as adopted and accepted by the American Dental Association (ADA), including charges for services and supplies which are experimental in nature: this provision also limits coverage to standard techniques and excludes specialized techniques.
8. Upgrading of serviceable dentistry.

9. Charges for the replacement of lost or stolen dentures, bridges or prosthetic devices.

10. Charges for duplicate prosthetic devices or the replacement of dentures, bridges or prosthetic devices less than three years old except as specifically provided in the Schedule.

11. Services performed or incurred before the Effective Date of the Individual’s Coverage under this Plan. A Dental Service is deemed to be incurred on the date such service or supply is rendered or received except with respect to:

   a) **Dentures or Fixed Bridges** – service is deemed to be incurred on the date the impression is taken;
   
   b) **Crowns** – service is deemed to be incurred on the date preparation of the tooth commenced; and
   
   c) **Root Canal Therapy** – service is deemed to be incurred on the date work commences on the tooth and the pulp chamber is opened.

12. Charges made for dental services performed after the termination date of the individual’s coverage under the Plan except for services performed within one month of such termination, which are needed to complete a Single Procedure, which commenced on or before the termination date.

13. Charges made for dental treatment or services in excess of the Eligible Expense or the Maximum Benefit payable.

14. Charges for Prophylaxis, Topical Fluoride Treatments and Oral Examinations which are provided before six months have elapsed from the date such service was previously provided.

15. Charges for tooth implants, myofunctional therapy and mouth guards.

16. Charges for training or counseling in oral hygiene.

17. Charges for the application of orthotic appliances and other non-surgical services for the treatment of Temporomandibular Joint Dysfunction (TMJ) or any other cranial facial or cervical spine syndrome.

18. Charges for Major Restorative services during the first 12 months of participation on the Dental plan.

IX – COORDINATION OF BENEFITS (COB)

DUPLICATION OF COVERAGE LIMITATION

If a Covered Individual is also covered or insured under any other group plan, including Medicare, the total services rendered to any one person or the total payment received for any one person from all programs combined, may not amount to more than 100% of the Allowable Expenses. Services and benefits are reduced only to the extent necessary to prevent an individual from making a profit on his Health and Dental Coverage Insurance. An Employee must report **Duplicate Group Health or Dental Coverage** on the
Statement of Claim he submits to secure reimbursement or to authorize payment of hospital, medical, surgical and dental expenses.

ALLOWABLE EXPENSES: Any necessary and reasonable health services or reasonable expenses for medical or dental treatment or supplies covered by one of the plans under which the individual is covered or insured. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service will be deemed to be both an Allowable Expense and a Benefit Paid.

PLAN: As used here, means any plan providing benefits or services for or by reason of medical or dental care or treatment which benefits or services are provided by:

a. Groups, blanket or franchise coverage;

b. Blue Cross, Blue Shield, Group Practice, Individual Practice or other payment coverage;

c. Any coverage under Labor-Management Trusteed Plans, Union Welfare Plans, Employer Organization Plans or Employee Benefit Organization Plans;

d. Any coverage under Governmental Programs or required or provided by statute. Such coverage excludes benefits received under No-Fault Insurance Laws of any state. Such coverage also excludes Welfare Benefits provided by the State, in which case this Plan will furnish benefits first; and

e. Any coverage provided through a school or educational institution.

The term PLAN shall be construed separately with respect to each policy, contract or other arrangement for benefits or services; and separately with respect to that portion of any such policy, contract or other arrangement which reserves the right to take benefits or services of other plans into consideration in determining benefits and that portion which does not.

ORDER OF BENEFIT DETERMINATION RULES

When duplicate coverage arises in Plans which: do not have a Coordination of Benefits (COB) Provision or use an Order of Benefit Determination Rules that differs from the accepted standards, such plan shall pay or provide their benefits first; and those that use the Standard COB and Order of Benefit Determination Rules will always pay second.

When the Coordination plans follow the uniform rules, the Order of Benefit Determination will be as follows:

1. EMPLOYEE/DEPENDENT. The plan which covers the Individual as an Employee pays first; while the plan covering the individual as a dependent pays benefits second.

2. DEPENDENT CHILDREN OF PARENTS NOT SEPARATED OR DIVORCED. The plan covering the parent whose birthday falls earlier in the year pays first; while the plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan which covered the parent longer pays first and the plan which covered the other parent for the shorter time pays second.
3. DEPENDENT CHILDREN OF SEPARATED OR DIVORCED PARENTS. If parents are separated or divorced the following rules apply:

a. The plan of the parent with custody pays first;

b. The plan of the parent with custody pays next and;

c. The plan of the spouse of the parent with custody (the step-parent) pays last.

Notwithstanding the above, if there is a Court Order requiring a person to assume financial responsibility for a dependent child’s medical, dental or other health care expenses, the plan that covers that person and the child will pay benefits first before all other plans covering the child as a dependent.

4. ACTIVE/INACTIVE EMPLOYEES. The plan covering the individual as an Active Employee (or as that individual’s Dependent) pays benefits first; while the plan which covers such individual as an inactive (laid-off or disabled) or Retired Employee (or as such individual’s dependent) pays benefits second. Further, if such Inactive Employee or Dependent is continuing coverage pursuant to the COBRA provision for a Pre-Existing condition clause, then this Plan will pay benefits first only for the Pre-Existing condition and be the secondary payor for all other Illness or Injury of such covered individual.

5. LONGER/SHORTER LENGTH OF SERVICE. If none of the above rules determine the Order of Benefits Payment, the plan which has covered the individual for the longer period of time will pay first and the plan covering the individual the shorter period of time pays second.

RIGHT TO RECEIVE OR RELEASE INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Provision or any provisions of similar purpose of any plan, the Plan Administrator may, without the consent of or notice to the Covered Individual, release to or obtain from any other insurance company or other organization or person, any information with respect to the Covered Individual, which the Plan Administrator deems necessary, for such purposes. Any Covered Individual claiming benefits under this Plan shall furnish the Plan Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments have been made under any other plan which should have been made under this Plan, the Plan shall have the right to pay over to such a plan the amounts it shall determine to be warranted in order to satisfy the intent of this coordination provision. These amounts so paid will be considered benefits paid under this Plan to the extent that they are applied toward Maximum Benefits, and the Plan shall be fully discharged of its liability.

RIGHT OF RECOVERY

If, at any time, the Plan has made payments in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Plan shall have the Right to Recover such excess payments. The Plan shall determine where such excess payment will be recovered from among one or more of the following: any person for whom or to whom such payments were made; any insurance company; or any other organization(s) or person(s).
X – BENEFIT CLAIM PROVISIONS

**BENEFITS:** If a Covered Individual receives dental services, the Plan agrees to pay the percentages indicated in the “Schedule of Dental Benefits” for the Maximum Benefits, limitations, specifications, exclusions and provisions of the Plan.

**PROOF OF CLAIM:** Written proof of claim for Dental Services incurred must be furnished to the Plan by the Covered Individual within ninety (90) days after the date such claim is incurred. Failure to furnish proof within this time will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided the proof is furnished no later than one year from the date such claim is incurred. Any claim for Benefits submitted over one year from the incurred date will not be covered under the Plan. A Dental Service is considered as incurred on the date the service or supplies are rendered or received except as specifically stated under the Plan’s **Exclusions & Limitations** for certain identified procedures and services.

Written proof will be satisfied when the Covered Employee completes a “Claim Form” (provided by the Employer) for the Covered Individual and submits this form along with itemized bills to the Claims Administrator. Only one Claim Form is required in each Plan Year unless the incurred Health Services are the result of an accident except for the short claim form provided by the Employer to be used for identification purposes each time the Covered Individual submits an itemized bill(s) for incurred services.

An itemized bill must indicate: the Covered Employee’s name and Subscriber number, the patient’s name and diagnosis, the Provider’s name and address, and list for each Health Service provided: the type of service or supply, date incurred, and charge (cost). A Health Service is considered as incurred on the date the service or supplies are rendered or received.

**TIMELINESS OF CLAIM PAYMENT:** Amounts payable under this Plan for any claim will be paid within a reasonable period of time after receipt of the due written Proof of Claim.

**PAYMENT OF CLAIM:** All Benefits will be paid directly to the Provider unless the Covered Employee provides a written itemized receipt that indicates the amount paid, service and/or supplies received, dates incurred, and from whom payment was received.

**CLAIM DENIAL & APPEAL PROCEDURE:** When a claim for benefits is denied, in whole or in part, the Plan will notify the Covered Individual in writing and indicate the reason for the claim denial, reference the Plan provision(s) applicable to the denial, request information which may allow the Covered Individual to correct the claim for proper processing; and apprise the Covered Individual as to the Claim Review & Appeal Procedures available under the Plan.

**Appeal Procedure**

The Appeal Procedure provides for the Covered Individual to file a written request with the Plan Administrator (or its representative) to review a Claim Denial within sixty (60) days after receiving the written notification of denial. The Covered Individual’s written appeal should include any information, material or evidence which supports his contention that such claim should be paid by the Plan.
The Plan Administrator will, in turn review the appeal and provide a written response to the Covered Individual within sixty (60) days of the receipt of the written appeal. The response shall document the specific reasons with reference to the Plan Provision(s) that the Plan Administrator utilized in making its decision to either concur in or set aside the previous claims disposition.

**RECORDS:** Each Covered Individual authorizes and directs any provider that has attended, examined or treated him, to furnish the Plan or its representative(s) at any time upon its request, any and all information and records or copies of records relating to the attendance, examination or treatment rendered to him and the Plan or its representative(s) agree that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Employee.

**RIGHT TO RECOVER PAYMENTS:** Any time the Plan has made benefit payments which are not required as set forth in the terms of this Plan Document, the Plan shall have the Right to Recover such payments from among any of the following: any person for whom or to whom such payments were made, any insurance company, or any other organization(s) or person(s).

**SUBROGATION:** In the event the Plan pays benefits on behalf of a Covered Individual who has the right to recover these benefits so paid under any other liability or casualty plan (exclusive of any individual disability plan), the Plan shall be subrogated to the extent of the Covered Individual’s rights of recovery against any person or entity who may be responsible, The Covered Individual shall execute and deliver instruments and papers, as requested by the Plan, and shall do nothing to prejudice the Plan’s right of subrogation. The Plan may initiate an action in the name of the Plan or the Covered Individual to assert its right of subrogation.

The amount of the Plan’s subrogated interest shall be deducted first from any recovery by or on behalf of the Covered Individual. The Plan will not be responsible for the Covered Individual’s attorney’s fees or other costs unless the Plan has agreed in writing to pay such fees or costs.

The Plan Administrator may appoint a third party to manage any necessary, non-litigated Subrogation proceedings up to a point when it is determined that an attorney must be hired. The Plan Administrator retains the right to hire and the financial responsibility for an attorney.

**XI – GENERAL PLAN PROVISIONS**

**AMENDMENTS OR TERMINATION:** The Plan may be amended, modified, changed (which includes the eligibility rules, increasing, decreasing and eliminating benefits, funding of benefits and all other matters) and/or terminated at any time by the Employer (including Officers and Appointed Plan Administrators) provided that such amendment or termination does not affect a Participant’s right to Benefits for covered incurred expenses under the Plan which are payable under the Plan Provisions Prior to any such amendment of termination. Benefits under this medical plan are not vested benefits. There is no guarantee that benefits will continue into the future. The Participants shall be notified in writing by the Plan Administrator of any amendments which significantly impacts the Benefits provided hereunder or upon termination. If the Plan terminates, the Plan assets will be used to pay for stop-loss insurance (if applicable), administrative fees and claims of the Plan. Any remaining assets (except for Employee Contributions) will remit to the Plan Sponsor.
APPLICABLE LAW: It is the intent of this Plan to comply with all applicable Federal and State laws. Whenever this Plan is in conflict with a State or Federal Law, the law will prevail over the Plan Provisions. However, if a State Law is in conflict with a Federal Law, the State Law is preempted under Federal Law.

BENEFITS ADMINISTRATOR: The firm or person(s) appointed by the Plan Administrator to be instilled with the responsibility to process claims and pay Benefits in accordance with the Plan provisions as provided in this Plan Document.

EMPLOYEE CONTRIBUTIONS: Any Employee Contributions to this Plan will be immediately applied to stop-loss insurance (if applicable) and administrative fees with any excesses being used to pay claims. The Employer determines the amount of Employee Contributions (as stated on a separate form) and reserves the right to adjust and modify these amounts. All such contributions are determined on a non-discriminatory basis.

EMPLOYER: Pride, Inc. and the following affiliated and/or subsidiary corporations, firms or associated individuals shall constitute the Employer: None With regard to an affiliate (and their Eligible Employees & Dependents) which is added to the Plan, such individuals are not eligible to participate prior to the effective date of addition. An affiliate (and their Covered Employees and Dependents) which terminates participation in the Plan and is no longer affiliated with the Employer ceases to have any rights under the Plan on and after the termination date.

INSPECTION OF PLAN: The Employer, upon request, shall make this Plan Document available for inspection by any participant in a reasonably accessible place.

INDEMNIFICATION: To the extent permitted by the law, the Plan Administrator shall indemnify and hold harmless any person(s) or service firm to whom the Plan Administrator has delegated fiduciary or other duties under the Plan, against any and all claims, losses, damages, expenses and liabilities arising from any act or failure to act that constitutes or is alleged to constitute a breach of such person’s or firm’s responsibilities in connection with the Plan under ERISA or any other law, unless the same is determined to be due to gross negligence, willful misconduct or willful failure to act. The Participant (Covered Employee or Covered Dependent) shall hold the Plan Administrator (Employer) harmless against any and all claims, losses or expenses resulting from such person or firm’s involvement in the administration of this Plan.

INTERPRETATION: This Plan shall not be deemed to constitute an employment contract between the Company and any Participant or to be a consideration or an inducement for the employment of any Participant or to be a consideration or an inducement for the employment of any Participant or otherwise change the at-will employment relationship between the Employer and Employee. Nothing contained in this Plan shall be deemed to give any Participant the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any participant or Employee at any time, regardless of the effect which such discharge will have upon that individual as a Participant in this Plan.

PARTICIPANT: A Plan Participant is each Employee and Family Dependent who satisfy the Eligibility Provisions of this Plan and voluntarily elects to participate in the Plan in accordance with the Enrollment requirements.

PLAN ADMINISTRATOR: The Employer (including any officers or directors) who sponsors this Welfare Benefit Plan for its Employees. The Plan shall be administered on a uniform and non-discriminatory basis for all Participants. All decisions regarding the rules, regulations or procedures for the administration of this Plan shall be made by the Plan Administrator who may employ, at its sole discretion, any individual or firm for the purpose of performing certain services essential to the day-to-day administration and operation of the Plan.
The Plan Administrator has full authority to make interpretations of the Plan and its written provisions and to exercise discretion in applying those provisions to claims. The decision of the Plan Administrator is full, final, and binding.

PRONOUNS: All personal pronouns used in this Plan Document and Summary Plan Description shall include either gender unless the context clearly indicates to the contrary.

XII – STATEMENT OF ERISA RIGHTS

As a participant in the Pride, Inc., Employee Dental Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and 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 Pension and Welfare Benefit Administration.

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

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, call “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan Document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such case, the court may require the Plan Administrator to provide the material and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in Federal Court. In addition, if you disagree with the Plan’s decision or lack thereof concerning a qualified medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal Court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay those costs and fees. If you lose, the court may order you to pay those costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

XIII - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Section 1 – USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the health Insurance Portability and Accountability Act of 1996 (HIPPA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility,
2. Coverage and Cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual’s claim);

3. Coordination of Benefits;

4. Adjudication of health benefit claims (including appeals and other payment disputes);

5. Establishing employee contributions;

6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

7. Billing, collection activities and related health care data processing;

8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);

10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;

11. Utilization review, including pre-authorization, concurrent review and retrospective review;

12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number and name and address of the provider and/or health plan) and;

13. Reimbursement to the Plan.

Health care operations include, but are not limited to, the following activities:

1. Quality assessment;

2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with full information about treatment alternatives and related functions;

3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

5. Conducting or arranging for dental review, legal services and auditing functions including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies.

7. Business management and general administrative activities of the Plan, including, but not limited to:
   a. Management activities relating to the implementation of and compliance with HIPPA’s administrative simplification requirements; or
   b. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

8. Resolution of internal grievances; and

9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a “covered entity” under HIPPA or, following completion of the sale or transfer, will become a covered entity.

SECTION 2 – THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY

With an authorization, the Plan will disclose PHI to the benefit plans or other separate plans of this Employer.

SECTION 3 – FOR PURPOSES OF THIS SECTION, THE EMPLOYER IS THE PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

SECTION 4 – WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;

2. Ensure that any agents, including a subcontractor and the Contract Administrator, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA’s access requirements;

7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8. Make available the information required to provide an account of disclosures;

9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the plan’s compliance with HIPAA; and

10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SECTION 5 – ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The benefits manager; and/or

2. Staff designated by the Benefits Manager.

SECTION 6 – LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons described in Section 5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

SECTION 7 – NONCOMPLIANCE ISSUES

If the persons described in Section 5 do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

XIV - HIPAA PRIVACY PROVISIONS

Effective April 14, 2004, the Privacy Rules under HIPAA apply to this Plan. For purposes of this Section, "Plan Sponsor" refers to the employer as the Plan Sponsor and as the entity capable of acting on behalf of the covered entity, the Plan.
(a) **Use and Disclosure of PHI.** The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

**Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual’s claim);
2. Coordination of benefits;
3. Adjudication of health benefits claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of provider and/or health Plan; and
13. Reimbursement to the Plan.

(b) Health care operations include, but are not limited to, the following activities:

1. Quality assessment;
(2) Population-based activities relating to improving health or reduction health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(3) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(4) Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

(5) Conducting or arranging for medical review, legal services and auditing function, including fraud and abuse detection and compliance programs;

(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(7) Business management and general administration activities of the Plan, including, but not limited to:
   a. Management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements;
   b. Customer service, including data analyses for policyholders;

(8) Resolution of internal grievances.

(9) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity under HIPAA or following completion of the sale or transfer, will become a covered entity.

(10) The Plan will use and disclose PHI as required by law and as permitted by authorization of the subject of PHI.

(11) With respect to PHI, the plan sponsor (as defined in the Privacy Rules under HIPAA) agrees to certain conditions. The Plan Sponsor agrees to:
   a. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
   b. Ensure that any agents, including a subcontractor, to whom the Plan provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
   c. Not use or disclose PHI for employment related actions and decision unless authorized by an individual;
d. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

e. Report to the Plan any PHI use or disclosure, that is inconsistent with the uses or disclosures provided for, of which it becomes aware;

f. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

g. Make available the information required to provide an accounting of disclosures;

h. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan’s compliance with HIPAA; and,

i. If feasible, return or destroy all PHI received for the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

(c) **Adequate separation between the Plan and the Plan Sponsor must be maintained.** In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The benefit manager; and,

2. Staff designated by the benefits manager.

(d) **Limitation of PHI Access and Disclosure.** The persons described in paragraph (c) above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

(e) **Noncompliance Issues.** If the person described in paragraph (c) above does not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including, but not limited to, disciplinary sanctions.
SUMMARY PLAN DESCRIPTION

PLAN NAME: Pride, Inc.
Employee Dental Benefit Plan

PLAN SPONSOR: Pride, Inc.
P.O. Box 4086
Bismarck, ND 58502-4046
701-258-7838

EMPLOYER FEDERAL (EIN) IDENTIFICATION NUMBER:

PLAN NUMBER:

TYPE OF ADMINISTRATION: The Plan is administered by the Plan Administrator with the help of the Benefit Administrator who is responsible for most aspects of the day-to-day operations of the Plan, including Claims Administration.

SOURCE OF PLAN CONTRIBUTIONS: The Employer and Employee

PLAN/FISCAL YEAR: The first Plan Year begins July 1, and ends June 30th. Thereafter, each subsequent Plan Year will begin July 1 and end on the succeeding June 30. The Fiscal Year is July 1st to June 30th.

CLAIM PROCEDURE: This is discussed in detail in this Summary Plan Description.

PLAN ADMINISTRATOR: Pride, Inc.
P.O. Box 4086
Bismarck, ND 58502-4046
888-588-6516

BENEFIT ADMINISTRATOR: HealthEZ
P.O. Box 398220
Minneapolis, MN 55439
888-588-6516

AGENT FOR SERVICE: Pride, Inc.
P.O. Box 4086
Bismarck, ND 58502-4046
ELIGIBILITY REQUIREMENTS, BENEFIT DESCRIPTIONS, CIRCUMSTANCES WHICH MAY CAUSE DISQUALIFICATION, INELIGIBILITY, DENIAL, LOSS, FORFEITURE OR SUSPENSION OF BENEFITS ARE DISCUSSED IN DETAIL IN THIS BENEFIT BOOKLET.

BY THIS AGREEMENT, Pride, Inc. (the Medical Plan) is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Pride, Inc. on or as of the day and year first below written.

By _________________________________

Pride, Inc.

Date________________________________

Witness _____________________________

Date________________________________