MIDWEST DENTAL
EMPLOYEE VISION BENEFIT PLAN
(CONTROL GROUP 8 - LAKE CHAUTAUQUA DENTAL, P.C.)

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective January 1, 2019

This document, together with the Exhibit(s) identified and incorporated by reference, constitutes the written plan document and SPD required by Section 402 of ERISA.

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ARTICLE I.
INTRODUCTION

Midwest Dental, Inc., the Plan Sponsor, has established the Midwest Dental Employee Vision Benefit Plan (Control Group 8 - Lake Chautauqua Dental, P.C.) (the "Plan") in order to provide vision benefits for Eligible Employees and their Dependents. This Plan is effective on January 1, 2019. The Plan operates on a Plan Year running from the first day of January through the last day of December.

Note: Words and phrases appearing in initial capital letters are defined terms. The complete definitions appear in the *Definitions Article* that appears at the end of this document. You are encouraged to consult the *Definitions Article* of this document.

Nature of the Plan
This Plan is a fully insured vision plan intended to meet the requirements under Sections 105 and 106 of the Code so any benefits received through this Plan are not taxable income to the Covered Employee.

Other things to note about the nature of the Plan include:

- Benefits are provided under an Insurance Policy entered into between the Plan Sponsor and the Insurer, a copy of which is attached hereto and incorporated into this document. Benefits under the Plan are described in the Insurance Policy and Certificate of Insurance issued by the Insurer, copies of which are attached hereto as Exhibit C and incorporated into this document.

- First American Administrators, Inc. and EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company, will process and pay Claims, as well as perform other administrative duties. Contact information for the Insurer appears at the end of this Article.

- This Plan is a group health plan for purposes of HIPAA Privacy Rules and Security Rules and will be administered in a manner consistent with those portions of HIPAA.
- This Plan is a stand-alone vision benefit plan for purposes of HIPAA Portability, and, therefore, not subject to the HIPAA Portability provision and not subject to the ACA mandates.

Written Document and SPD
This document serves as both the written plan document required under ERISA, and the Summary Plan Description (SPD) required under ERISA. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under this Plan. The document should be read in its entirety because many of the provisions are interrelated.

This Plan does not pay all vision expenses. It pays ***certain*** expenses under ***certain*** circumstances.

Important: Just because a Provider recommends or prescribes a course of treatment does not mean the cost of it is paid by this Plan.

For an expense to be "covered" under this Plan, a number of requirements must be met, Including:

(a) the person must be a Covered Individual;

(b) the service giving rise to the expense must be a Covered Service;

(c) the expense for the Covered Service must meet the requirements of a Covered Charge; and

(d) any applicable Cost Sharing Amounts must be met (e.g., a Co-payment).

This Plan document provides you with the information necessary to determine whether and to what degree a particular expense is "covered" under this Plan and, therefore, the financial responsibility of this Plan.

Questions

The Insurer's customer service representatives are available to answer any questions or concerns regarding this Plan, Including eligibility and enrollment questions. You may contact the Insurer at 1-866-939-3633 or www.eyemedvisioncare.com.

ARTICLE II.
SUMMARY

2.1 **How to Use This Document**. This document consists of several parts. All of the parts of this document work together. The *Introduction Article* provides a variety of information a person covered under this Plan should know. The *Summary Article* provides an overview of key provisions of the Plan, Including the *Vision Benefits Schedule* together with the *Defined Terms Article* that appears at the end of this document. These Articles provide a good summary of what is available through this Plan. In many cases, there will not be a need to look anywhere else. However, when a Covered Individual has a particular condition, or a particular treatment is being considered, the description(s) in the *Vision Benefits Schedule* should also be reviewed. The *Summary Article* contains numerous references to other portions of the Plan. In addition, the Table of Contents can be used as an index to specific topics discussed throughout the document.

2.2 **Vision Benefits Cost Sharing Amount**. The Cost Sharing Amount refers to the portion of the cost of a Covered Charge for which a Covered Individual is responsible for paying out of pocket.

(a) **Co-payment.** In general, Co-payment refers to the flat dollar per occurrence amount for which the Covered Individual is responsible. Co-payment is a defined term. Covered Services subject to Co-payments are listed in the applicable *Exhibit A: Vision Benefits Schedule.* More detail regarding this term may be found in the *Defined Terms Article* that appears at the end of this document.

(b) **Maximum.** In general, a Maximum refers to the total dollar amount payable under the Plan for certain Covered Services. Maximums are listed in the applicable *Vision Benefits Schedule*. More detail regarding this term may be found in the *Defined Terms Article* that appears at the end of this document. When the Maximum has been met, this Plan pays no further amounts for that Covered Service.

2.3 **Vision Benefits Schedule**. A summary of the benefits under this Plan appears in *Exhibit A: Vision Benefits Schedule*.

Note: The *Vision Benefits Schedule* is a snapshot of the terms and conditions of the Plan. It is not intended to be comprehensive.

2.4 **Vision Charge Incurred Date.** A charge is incurred on the actual date a specific service is rendered or supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are Incurred for the various steps of phases as the services related to each step are rendered, not when services relating to the initial step or phase are rendered.

2.5 **Making and Determining a Claim**. In order for a Covered Charge to be paid by the Plan, a Claim must be properly and timely submitted. This Plan recognizes Post-Service Claims, which shall be determined as described in Exhibit A and the claims and appeals provisions of the Insurance Policy and Certificate of Insurance, incorporated by reference into this Plan.

2.6 **Assignments**. This Plan only recognizes an assignment by the Covered Individual to the Provider that provides the Covered Services.

2.7 **Subrogation, Reimbursement & Recovery**. In general, this Plan reserves the right to take action to make the Plan whole when another person is responsible for all or a portion of the Covered Services. This Plan also reserves the right to seek recovery if the Plan makes any payments in error, Including an error with respect to the amount paid or an error with respect to the party paid. These provisions are described in

more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer; incorporated by reference into this Plan.

Important: Cooperation with the Plan regarding these situations is a ***condition of coverage*** under the Plan.

2.8 **HIPAA Privacy and Security Rules**. The Plan is considered a "covered entity" for purposes of the HIPAA Privacy and Security rules. The Insurer is primarily responsible for ensuring the Plan complies with those rules. Please contact the Insurer for additional information.

2.9 **Continuation Rights under COBRA**. COBRA requires most employers to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. The Plan shall be operated consistent with COBRA as described in the Plan's COBRA Initial Notice of Rights, which is incorporated by reference into the Plan and this SPD (this document is available to you upon request, at no charge).

2.10 **Continuation Rights and USERRA**

Note: Although USERRA protections look similar to COBRA protections, USERRA rights are separate and independent from COBRA rights.

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under USERRA for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation rights under COBRA (if any). The Plan shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD (this document is available to you upon request, at no charge).

2.11 **ERISA Plan Information**

The following information about this Plan is important for Covered Individuals to know, and much of it is required to be provided.

Name of Plan:	Midwest Dental Employee Vision Benefit Plan (Control Group 8 - Lake Chautauqua Dental, P.C.)
Plan Sponsor:	Midwest Dental, Inc. 680 Hehli Way PO Box 69 Mondovi, WI 54755 Phone: 715-926-5050
Plan Sponsor's Federal Tax Identification Number:	39-2043208
ERISA Plan Number	503

Plan Administrator:	Midwest Dental, Inc. 680 Hehli Way PO Box 69 Mondovi, WI 54755 Phone: 715-926-5050
Insurer:	EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 www.eyemedvisioncare.com *Underwritten by:* Fidelity Security Life Insurance Company 3130 Broadway PO Box 418131 Kansas City, MO 64141-8131 Policy No. VC-19 / VC-20
Claims Administrator:	First American Administrators, Inc. on behalf of EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 www.eyemedvisioncare.com
Named Fiduciary:	*For benefits provided under the Insurance Policy and Certificate of Insurance:* EyeMed Vision Care 4000 Luxottica Place Mason, OH 45040 *Underwritten by:* Fidelity Security Life Insurance Company 3130 Broadway PO Box 418131 Kansas City, MO 64141-8131 *For all other matters:* Midwest Dental, Inc. 680 Hehli Way PO Box 69 Mondovi, WI 54755 Phone: 715-926-5050
Participating Employers:	Business entities which are members of the same controlled group identified in Exhibit B.

Agent for Service of Legal Process:	Midwest Dental, Inc. 680 Hehli Way PO Box 69 Mondovi, WI 54755 Attn: Human Resources Legal process may also be served on the Plan Administrator.
Funding Medium and Type of Plan Administration:	The Plan is fully insured. Benefits are provided under the Insurance Policy entered into between the Plan Sponsor and the Insurer. Claims for benefits are sent to the Insurer's designee, First American Administrators, Inc. on behalf of EyeMed Vision Care. The Insurer (not the Plan Sponsor, Plan Administrator, or Employer) is responsible for paying benefits. Note, however, that the Insurer and the Plan Administrator share responsibility for administering the Plan. Coverage Premiums for Participants are paid by the Participants through pre-tax payroll deductions and/or after-tax payments. The Employer provides a schedule of the applicable premiums; contact the Employer if you need another copy.
Type of Participants covered under the Plan:	All Eligible Employees of the participating Employers.
Plan Modifications:	Any amendments to, or termination, of the Plan will be accomplished by, or pursuant to, a written resolution of the Plan Sponsor.
Plan Year:	January 1 through December 31

There is no trust and, therefore, no trustees.

2.12 **ERISA Statement of Rights**. A Covered Employee under this Plan is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Employees shall be entitled to:

(a) **Receive Information About This Plan and Benefits**.

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing this Plan, Including insurance contracts and collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 Series) if required to be filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(2) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of this Plan, Including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

(3) Receive a summary of this Plan's annual financial report, if an annual financial report is required. The Plan Administrator is required by law to furnish Covered Employees with a copy of this summary annual report.

(b) **COBRA Rights**. As a Covered Employee in the Plan you may be able to continue coverage for yourself and your Dependents if there is a loss in 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 regarding the rules governing your COBRA continuation coverage rights.

Note: Not all Employers are subject to COBRA and not all Employees are eligible for COBRA. Check with your Employer or the Plan Sponsor.

(c) **Prudent Actions by Plan Fiduciaries**. In addition to creating rights for Covered Employees, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Employees. No one, Including the Employer, a union, or any other person, may fire an Employee or otherwise discriminate against an Employee in any way to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

(d) **Enforce Rights**

(1) If a Claim for a welfare benefit is denied or ignored, in whole or in part, a Covered Employee has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

(2) Under ERISA, there are steps Covered Employees can take to enforce the above rights. For instance, if a Covered Employee requests a copy of Plan documents or the latest annual report from this Plan and does not receive them within thirty (30) days, the Covered Employee may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Employee up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Employee has a Claim for benefits which is denied or ignored, in whole or in part, the Covered Employee may file suit in a state or Federal court after exhausting the appeal procedures provided in this Plan. In addition, if a Covered Employee disagrees with this Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Employee may file suit in Federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Covered Employee is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Covered Employee is successful the court may order the person he/she has sued to pay these costs and fees. If the Covered Employee loses, the court may order the Covered Employee to pay these costs and fees, for example, if it finds the Claim is frivolous.

(3) **Exhaustion of Administrative Procedures Required**. To the fullest extent permitted under applicable law, the right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. *Failure to exhaust administrative procedures may preclude you from bringing an action in court*.

(e) **Assistance with Questions**

(1) For questions about this Plan, contact the Plan Administrator.

(2) For questions about this statement or about a Covered Employee's rights under ERISA, or if a Covered Employee needs assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

(3) A Covered Employee may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE III.
ELIGIBILITY, ENROLLMENT, TERMINATION PROVISIONS AND FUNDING

3.1 **Eligibility Requirements, Waiting Period, and Coverage for Employee**. An Employee is eligible to enroll in the Plan if the Employee is scheduled to work 25 or more hours each week. An Eligible Employee may begin participation in the Plan on the first day of the month coinciding with, or following, thirty (30) days of employment with the Employer.

3.2 **Eligibility Requirements, Waiting Period, and Coverage for Dependents.** Coverage is only available to a Dependent if the Employee is covered under the Plan as described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer, incorporated by reference.

3.3 **Enrollment Requirements.**

(a) **Initial Enrollment Requirements**. An Eligible Employee must enroll in the Plan in order to actually be covered under the Plan. The Plan Administrator may require the completion and timely submission of enrollment form(s) that provide the Plan with the information it has determined is necessary to operate the Plan. An Eligible Employee can enroll its Dependents. Such Dependent coverage requires the Eligible Employee to either already be actually covered under the Plan, or be starting coverage at the same time as the Dependents.

(b) **Ongoing Enrollment**. As part of annual enrollment, a Covered Individual (i.e., Covered Employee or Covered Dependent) may, with respect to the upcoming Plan Year, choose to continue coverage under the Plan or choose to stop coverage under the Plan. However, in order for a Covered Dependent to continue coverage under the Plan, the Covered Employee must also continue coverage under the Plan. The Plan Administrator may require the completion and timely submission of enrollment form(s) that provide the Plan with the information it has determined is necessary to operate the Plan.

3.4 **Employee Termination of Coverage**. The termination of Employee coverage is described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

3.5 **Coverage during a Family and Medical Leave Act (FMLA) Leave**. Coverage during an FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law.

3.6 **Rehiring a Terminated Employee**. A terminated Employee who is rehired is described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

3.7 **Dependent Termination of Coverage**. A Dependent's coverage will terminate as described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

3.8 **Retroactive Termination**. Coverage may be retroactively terminated. Claims Incurred after the retroactive date of termination under this Plan shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid Claims under this Plan.

3.9 **Funding**. For each Plan Year, the Employer determines the amount of Covered Employee contributions, if any, that Covered Individuals or any subgroup of Covered Employees will be required to pay for coverage under this Plan. The portion of the cost of coverage for which the Covered Employee is responsible may be paid by the Covered Employee on a pre-tax basis through a cafeteria plan of the Employer, or Plan Sponsor, if such a plan is made available by the Employer, or Plan Sponsor, and the Covered Employee meets the eligibility requirements of the cafeteria plan.

ARTICLE IV.
VISION BENEFITS

If you Incur expenses for the Covered Services described below, the Plan will pay benefits as shown in the applicable schedule of benefits (based upon the coverage option chosen) found in the *Exhibit A: Vision Benefits Schedule*.

Note: The *Vision Benefits Schedule* is a snapshot of the terms and conditions of the Plan. It is not intended to be comprehensive. More detail information is contained in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

Covered Vision Care Expenses

Depending on the coverage option selected by the Participant, Covered Services Include either routine eye examinations, materials (frames and lenses) and contact lenses, or only materials (frames and lenses) and contact lenses, up to the limitations described in *Exhibit A: Vision Benefits Schedule*. To be a Covered Service, it must be provided by or recommended by a Provider.

Charges for materials (frames/lenses) or contacts will be considered Incurred on the date ordered, for purposes of this Plan.

ARTICLE V.
VISION PLAN EXCLUSIONS

Exclusions are described in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

ARTICLE VI.
COORDINATION OF BENEFITS

Benefits under this Plan are coordinated with Other Coverage as described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

ARTICLE VII.
THIRD PARTY RECOVERY, SUBROGATION & ERRONEOUS PAYMENT

Benefits paid under this Plan are subject to the provisions described in more detail in the Insurance Policy and Certificate of Insurance issued by the Insurer and incorporated by reference.

ARTICLE VIII.
PLAN ADMINISTRATION

8.1 **Plan Administrator**. The Plan Administrator shall be responsible for the general supervision of the Plan. The Plan Administrator shall also be a named fiduciary of the Plan in accordance with Section 402 of ERISA and, therefore, shall have the discretionary authority to control and manage the operation and administration of the Plan including, but not limited to, the interpretation and application of the terms of the Plan. The Plan Administrator shall perform any and all acts necessary or appropriate for the proper management and administration of the Plan.

The Plan Sponsor shall be the Plan Administrator unless its managing body designates a person or persons other than the Plan Sponsor to be the Plan Administrator. The Plan Sponsor shall also be the Plan Administrator if the person or persons so designated for any reason cease to be the Plan Administrator.

The Plan Administrator may designate individuals or entities to act on its behalf with respect to certain powers, duties, responsibilities, etc. with respect to the operation and administration of the Plan.

8.2 **Allocation of Responsibility for Administration**. The Plan Administrator shall have the sole responsibility for the administration of the Plan as is specifically described in the Plan. The designated representatives of the Plan Administrator shall have only those specific powers, duties, responsibilities, and obligations as are specifically given to them under the Plan including the Insurance Policy and Certificate of Insurance. The Plan Administrator warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan authorizing or providing for such direction, information or action. It is intended under the Plan that the Plan Administrator shall be responsible for the proper exercise of its own powers, duties, responsibilities, and obligations under the Plan and shall not be responsible for any act or failure to act of another Employee of the Employer. Neither the Plan Administrator (including any designee) nor the Employer makes any guarantee to any Participant in any manner for any loss or other event because of the Participant's participation in the Plan.

8.3 **Rules and Decisions**. Except as otherwise specifically provided in the Plan, the Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Employer, and/or legal counsel.

8.4 **Records and Reports**. The Plan Administrator shall be responsible for complying with all reporting, filing and disclosure requirements for the Plan.

8.5 **Other Powers and Duties of the Plan Administrator**. The Plan Administrator, or its designee, shall also have such other duties and powers as may be necessary to discharge its duties under the Plan including, but not limited to, the following:

(a) except to the extent otherwise addressed and governed by an Insurance Policy and Certificate of Insurance, discretion to construe and interpret the Plan in a non-discriminatory manner, to decide all questions of eligibility, and determine all questions arising in the administration and application of the Plan;

(b) to receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;

(c) to furnish the Employer, upon request, such annual reports with respect to the administration of the Plan as are reasonable and appropriate; and

(d) to appoint individuals to assist in the administration of the Plan and any other agents he or she deems advisable including legal and actuarial counsel. The Plan Administrator shall not have the power to add to, subtract from, or modify any of the terms of the Plan, to change or add to any benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a benefit under the Plan.

8.6 **Indemnification**. To the maximum extent allowed by, and in accordance with, applicable law, the Employer shall indemnify and hold harmless any Employee that is deemed to be a fiduciary against any and all losses, claims, damages, expense (including court costs and attorneys' fees), and liability arising from the Employee's duties and responsibilities in connection with the Plan, unless the same is determined to be intentional or willful.

8.7 **Changes by the Plan Administrator**. If the Plan Administrator determines before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by applicable law, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to further compliance with such requirements or limitation. Such action may include, without limitation, a modification of coverage for certain Participants and a re-characterization within the Plan Year of benefits provided under the Plan as taxable income with or without consent of such Participant.

8.8 **Compliance with Applicable Law**. The Plan Administrator shall operate the Plan in compliance with applicable law including, but not limited to, ERISA. In the event it is determined that the Plan is not compliant with applicable law, the Plan Administrator may take any appropriate action necessary to bring the Plan into compliance.

8.9 **Amending and Terminating the Plan**. The Plan Sponsor expects to maintain the Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Covered Individuals are limited to expenses incurred before termination. Benefits will be paid only for Covered Services incurred prior to the termination date. All amendments to the Plan shall become effective as of a date established by the Plan Sponsor.

ARTICLE IX.
GENERAL PROVISIONS

9.1 **Applicable Law**. This is a fully insured benefit plan subject to state regulations of the insurance industry. In the event it is determined that the Plan is not compliant with applicable law, the Plan Administrator may take any appropriate action necessary to bring the Plan into compliance.

9.2 **Conformity with Governing Law**. It is intended that this Plan shall comply with all applicable law. If any provision of this Plan is contrary to any law to which it is subject, such provisions is hereby amended to conform thereto.

9.3 **Type of Administration**. The Plan is a fully insured group health plan and the administration is provided through an insurance company. The funding for the benefits is derived from the funds of the Employer and contributions made by Covered Employees.

9.4 **Not a Contract**. This Plan document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan document shall not be deemed to constitute a contract of any type between the Employer and any Covered Individual or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan document shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Employer with the bargaining representatives of any Employees.

9.5 **Legal Entity**. This Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

9.6 **Nondiscrimination.** This Plan will not discriminate against any Covered Individual based on race, color, religion, national origin, disability, gender, sexual preference, or age. This Plan will not establish rules for eligibility based on health status, medical condition, Claims experience, receipt of healthcare, medical history, evidence of insurability, genetic information, or disability.

9.7 **Action by Plan Sponsor.** Unless otherwise specifically stated in this Plan, whenever the Plan Sponsor, under the terms of the Plan, is permitted or required to do or perform any act or matter or thing, it shall be done and performed by the managing body of the Plan Sponsor or such representatives of the Plan Sponsor as the managing body may designate.

9.8 **No Right to Employer's Assets.** No Participant or beneficiary thereof shall have any right to, or interest in, any assets of the Employer upon termination of employment, or otherwise except as provided from time to time under the Plan, and then only to the extent of the benefits payable under the Plan to such Participant or beneficiary thereof.

9.9 **Non-Alienation of Benefits.** Benefits payable under the Plan shall not be subject to anticipation, alienation, sale, transfer, execution, or levy of any kind either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse, or for any other relative of the Participant, prior to actually being received by the person entitled to the benefit under the terms of the Plan. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable under the Plan shall be void. The Plan Sponsor, Employer, Plan Administrator, and/or Insurer shall not in any manner be made liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under the Plan.

9.10 **Indemnification of Employer by Participants.** To the maximum extent allowed by, and in accordance with, applicable law, if any Participant receives one or more payments or reimbursements under this Plan that are not for eligible expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold including federal or state income tax or Social Security or Medicare tax from such payment or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security or Medicare tax that would have been paid on such compensation, less any such additional income and Social Security or Medicare tax actually paid by the Participant.

9.11 **Mistakes and Errors.** It is recognized that in the administration of the Plan, certain administrative and accounting errors may be made or situations may arise by reason of factual errors in information supplied to the Employer or the Plan Administrator. The Plan Sponsor, Employer and/or the Plan Administrator shall have the power to take such equitable steps as may be necessary to correct the mathematical, accounting or factual errors, as they, in their sole discretion, determine(s) to be appropriate.

9.12 **Additional Benefits.** Nothing under the Plan precludes the Plan Sponsor from providing additional benefits to a Participant who is also receiving benefits under the Plan including, but not limited to, benefits that require receipt of benefits under the Plan as a pre-condition to receiving benefits under such other plan or program. However, nothing in such other plan or program shall be construed as amending or in any other way influencing the administration of the Plan.

9.13 **Gender and Number.** Pronoun references in this Plan shall be deemed to be of any gender relevant to the context, and words used in the singular may also include the plural.

9.14 **Exhaustion of Administrative Remedies; Statute of Limitations.** For all claims subject to the administrative procedures described in the Insurance Policy and Certificate of Insurance or Exhibit A, exhaustion of those administrative procedures is required prior to the initiation of a legal action. Thereafter, legal action by a Participant, or someone on behalf of a Participant, must be initiated within one (1) year of receipt of the written notification of denial upon appeal, unless a longer period is provided under the Insurance Policy and Certificate of Insurance. To the extent exhaustion of the appeal process is not required, a Participant, or someone on behalf of the Participant, must initiate legal action within one (1) year of having submitted the initial claim request to the Plan Administrator, or its designee, unless a longer period is provided under the Insurance Policy and Certificate of Insurance. No legal action may be brought by a Participant, or someone on behalf of the Participant, after expiration of the applicable limitations period.

ARTICLE X.
DEFINED TERMS

This Article defines the terms used in this Plan. These terms appear in initial capital letters throughout this Plan when referred to in the context defined.

Certificate of Insurance: the "certificate of insurance" issued to the Plan Sponsor by the Insurer.

Claim: a submission to the Plan for payment made under the Plan in accordance with the Plan requirements.

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

Code: the Internal Revenue Code of 1986, as amended.

Cost Sharing Amounts: the dollar amount a Covered Individual is responsible for paying when Covered Services are received from a Provider. Cost Sharing Amounts Include Co-payment amounts. Cost Sharing Amounts are identified in the applicable *Schedule A: Vision Benefits Schedule*. A Provider may bill a Covered Individual directly or request payment of Cost Sharing Amounts at the time Covered Services are provided.

(a) **Co-payment** - the amount a Covered Individual must pay for certain Covered Services. Covered Services subject to a Co-payment are listed in the applicable *Vision Benefits Schedule.* A Co-payment is a flat dollar amount. In some instances, the Covered Individual will be responsible at the time and place of service to pay any Co-payment directly to the Provider. In other instances, the Covered Individual will be billed by the Provider. These arrangements are between the Covered Individual and the Provider.

(b) **Maximums** - the total dollar amount payable for certain Covered Services. Maximums are listed in the applicable *Schedule A: Vision Benefits Schedule*. When the Maximum has been met, this Plan pays no further amounts for that Covered Service.

Covered Charge(s): the charge, or portion of the charge, by a Provider for Covered Services eligible for payment under this Plan. The maximum Covered Charge is the lesser of (1) the "usual and customary rate," and (2) any specific charge (i.e., flat dollar amount) stated in the Plan either directly or through incorporation by reference.

Covered Dependent: a Dependent who is participating under this Plan in accordance with the *Eligibility, Enrollment, Termination Provisions and Funding Article* and whose coverage has not terminated.

Covered Employee: an Employee who is participating under this Plan in accordance with the *Eligibility, Enrollment, Termination Provisions and Funding Article* and whose coverage has not terminated. Covered Employee may also Include a retired Employee participating in this Plan in accordance with the *Eligibility, Enrollment, Termination Provisions and Funding Article* and whose coverage has not terminated.

Covered Individual: a Covered Employee or Covered Dependent who is participating under this Plan in accordance with the *Eligibility, Enrollment, Termination Provisions and Funding Article* and whose coverage has not terminated. Covered Individual also includes former Covered Employees and former Covered Dependents who are otherwise entitled to coverage and properly enrolled under this Plan.

Covered Services: the vision services described in this Plan for which Plan benefits are payable, to the extent described in the Plan and unless otherwise limited or excluded by the Plan.

Dependent: any of the following persons whose coverage under the Insurance Policy is in force and has not ended:

1. the Covered Employee's Spouse;

2. each unmarried child from birth to age 19 who is primarily dependent upon the Covered Employee or the Covered Employee's Spouse for support and maintenance;

3. each unmarried child at least 19 years of age to 25 years of age who is primarily dependent upon the Covered Employee or the Covered Employee's Spouse for support and maintenance and who is a full-time student; or

4. each unmarried child at least 19 years of age: who is primarily dependent upon the Covered Employee or the Covered Employee's Spouse for support and maintenance because the child is incapable of self-sustaining employment by reason of mental incapacity or physical handicap; who was so incapacitated and is a Covered Individual under the Policy on his or her 19th birthday; and who has been continuously so incapacitated since his or her 19th birthday.

"Child" includes stepchild, foster child, legally adopted child, child legally placed in the Insured's home for adoption and child under the Insured's legal guardianship. A "full-time student" is one who is enrolled at least the minimum number of hours of class a week the school considers as full-time status.

Eligible Employee: an Employee or former Employee who meets the eligibility criteria for this Plan as described in the *Eligibility, Enrollment, Termination Provisions and Funding Article* and who has not ceased to meet the eligibility criteria.

Employee: any person employed by the Employer on or after the Effective Date, except that it shall not include:

(a) any individual included within a unit of Employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under this Plan;

(b) any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;

(c) any leased Employee (including, but not limited to, those individuals defined in Code Section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary Employee or casual Employee, whether or not any such persons are on the Employer's W-2 payroll or are determined by the IRS or others to be common-law Employees of the Employer; or

(d) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency such as "Kelly," "Manpower," etc., whether or not such individuals are determined by the IRS or others to be common-law Employees of the Employer.

Employer: the entities identified in Exhibit C.

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

FMLA: the Family and Medical Leave Act of 1993, as amended.

HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.

Including: Including, but not limited to.

Incurred (or Incur): a Covered Charge is Incurred based on the definition that appears in Section 2.4 of this Plan.

Insurance Policy: the "insurance policy" issued to the Plan Sponsor by the Insurer.

Insurer: the insurance company licensed to do business in the state in which the Insurance Policy and Certificate of Insurance have been issued.

Named Fiduciary: shall be the entities named in Section 2.11 of this Plan.

Other Coverage: shall Include:

(a) Any primary payer besides the Plan;

(b) Any other group health plan;

(c) Any other coverage or policy covering the Covered Individual;

(d) Any first party insurance through medical payment coverage, personal injury protection;

(e) No-Fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

(f) Any policy of insurance from any insurance company or guarantor of a responsible party;

(g) Any policy of insurance from any insurance company or guarantor of a third party;

(h) Workers' compensation or other liability insurance company; or

(i) Any other source Including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Plan: the Midwest Dental Employee Vision Benefit Plan (Control Group 8 - Lake Chautauqua Dental, P.C.).

Plan Administrator: the Plan Administrator is Midwest Dental, Inc.

Plan Sponsor: Midwest Dental, Inc., on behalf of the Employer(s).

Plan Year: the twelve (12) month period beginning on the first day of January and ending on the last day of December.

Post-Service Claim: any Claim for a benefit under this Plan that is submitted for payment or reimbursement after the services have been rendered.

Privacy Rules: the *Standards and Privacy of Individually Identifiable Health Information* at 45 C.F.R. Part 160 and Part 164 at subparts A and E.

Provider: physician, ophthalmologists, optometrists, opticians and retail optical locations consisting of vision exams, materials, and contact lenses.

Security Rules: the *Security Standards and Implementation Specifications* at 45 C.F.R. Part 160 and Part 164, subpart C.

Spouse: the person to whom the Covered Employee is legally married.

USERRA: the Uniformed Services Employment and Reemployment Rights Act of 1994.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan document to be executed.

Midwest Dental, Inc.

By: M. Beemer

Its: VP of HR

EXHIBIT A
CLAIM AND APPEAL PROCEDURES

A.1 **Introduction**. To the extent the Insurance Policy and Certificate of Insurance do not contain a claims and appeal procedure compliant with ERISA, this Exhibit A shall apply with respect to the Benefits available through this Plan. All Claims must be submitted to this Plan and all claims review must comply with the rules and procedures set forth in this Plan.

A.2 **Claim Submission**. A claim must be made in writing and submitted to the Plan in accordance with the procedures described in the Insurance Policy and Certificate of Insurance.

A.3 **Initial Claim Determination**.

(a) **Time Frame for Decision.** The decision maker must determine the Claim within a reasonable period of time not to exceed thirty (30) days of receipt of the Claim.

(b) **Extension of Tim**e. If the decision maker is not able to determine the Claim within this time period due to matters beyond its control, the decision maker may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, the decision maker must notify the Claimant or the Claimant's Authorized Representative of the need prior to the expiration of the initial thirty (30) day time period for determining the Claim. This extension is only available once.

> **Notification**: The notification of the need for the extension must include a description of the "matters beyond the Plan's control" that justify the extension and the date by which a decision is expected.

(c) **Incomplete Claims**. Incomplete Claims can be addressed through the extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, the decision maker's period of time to make a decision is "tolled."

> **Tolling**: The period of time in which the decision maker must determine a Claim is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds.

If additional information is requested, the Claimant will have forty-five (45) days to provide the information. The notification will include a time frame in which the necessary information must be provided. Once the necessary information has been provided, the decision maker must decide the Claim within the extension described above. If the requested information is not provided within the time specified, the Claim may be decided without that information.

A.4 **Decision**.

(a) **Notification of Decision**. Written (or electronic) notification of the decision maker's determination must be provided to the Claimant or the Claimant's Authorized Representative only where the decision is adverse.

> "Adverse" means: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

(b) **Adverse Decision**. For adverse Claim determinations, the notification shall reflect at least the following:

(1) The specific reason(s) for determination;
(2) The specific Plan provision(s) upon which the determination is based;
(3) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
(4) Description of the Plan's procedures and time limits for appealing the determination, and the right to obtain information about those procedures and the right to sue in federal court;
(5) A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
(6) Where the decision involves scientific or clinical judgment, disclose either (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to Claimant or the Claimant's authorized representative's medical circumstances, or (ii) a statement that such explanation will be provided at no charge upon request.

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

A.5 **Access to Relevant Documents**. In order to (a) evaluate whether to request review of an adverse determination, and (b) if review is requested, to prepare for such review, the Claimant or the Claimant's Authorized Representative will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations.

Relevant: A document, record or other information is "relevant" if it was relied upon in making the determination, or was submitted to the Plan, considered by the Plan, or generated in the course of making the benefit determination without regard to whether it was relied upon.

A.6 **Appeal a Denied Claim.** If a Claim is denied, in whole or part, the Claimant or the Claimant's Authorized Representative may request the denied Claim be reviewed.

(a) **Requesting Review**. The Claimant or the Claimant's Authorized Representative has a period of one hundred eighty (180) days after receiving notice of the denial to appeal the Claim determination. The appeal request must be in writing and should be sent to the address specified in the notification of adverse decision described above.

(b) **Submission & Consideration of Comments**. The Claimant or the Claimant's Authorized Representative will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the adverse benefit determinations will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(c) **Consultation with Independent Medical Expert**. In the case of a Claim denied on the grounds of a medical judgment, a health professional with appropriate training and experience will be consulted. The health care professional who is consulted on appeal will not be the individual who was consulted, if any, during the initial determination or a subordinate of that individual.

Disclosure: If the advice of a medical or vocational expert was obtained by the Plan in connection with the Claim denial, the names of each such expert shall be provided, regardless of whether the advice was relied upon.

(d) **Time Frame for Decision**. If Claimant or the Claimant's Authorized Representative requests a review of a denied Claim within the time frame described above, the decision maker shall review of Claim and make a determination within a reasonable period of time not to exceed sixty (60) days from the date the review request was received.

(e) **Decision**. The review of the Claim will be conducted by the Plan Administrator or its designee. It will be made by a person different from the person who made the initial determination and such person will not be a subordinate of the original decision maker. The information in the administrative record shall be reviewed. Additional information submitted shall be considered. The decision shall be based upon that information plus the terms of the `Plan and past interpretations of the same and similar Plan provisions. The decision maker may rely upon protocols, guidelines, or other criterion.

(f) **Notification of Decision**. Written (or electronic) notification of the decision maker's determination must be provided to the Claimant or the Claimant's Authorized Representative. Such notification must be provided whether the decision is adverse or not adverse.

"Adverse" means: A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

(g) Adverse Decision. For adverse appeal determinations, the notification shall reflect at least the following:

(1) The specific reason(s) for determination;
(2) The reference specific Plan provision(s) upon which the determination is based;
(3) Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
(4) A statement indicating entitlement to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination; and
(5) Where the decision involves scientific or clinical judgment, disclose either (i) an explanation of the scientific or clinical judgment applying the terms of the Plan to Claimant's medical circumstances, or (ii) a statement that such explanation will be provided at no charge upon request.

Notice of the adverse determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with applicable legal requirements.

(h) **Not Adverse Decision**. For appeal determinations that are not adverse, notice will be provided that informs the Claimant or the Claimant's Authorized Representative the decision has been reversed, and the Claim accepted.

EXHIBIT B: VISION BENEFITS SCHEDULE

As of January 1, 2019:

Exams/Materials:

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Co-payment	up to $40	12 months
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$25 Co-payment	up to $30	
Bifocal	$25 Co-payment	up to $50	
Trifocal	$25 Co-payment	up to $70	
Lenticular	$25 Co-payment	up to $70	
Frames	$0 Co-payment, up to $130 retail allowance	up to $91	24 months
Contact Lenses *(only one option available per Benefit Frequency)*			12 months
Conventional	$0 Co-payment, up to $130 allowance	up to $130	
Disposable	$0 Co-payment, up to $130 allowance	up to $130	
Medically Necessary	Paid in full	up to $210	
Lens Options			12 months
Standard Progressive Lenses (add on to Bifocal)	$90 Co-payment	up to $50	
Premium Progressive Lenses (add on to Bifocal)	$90 Co-payment, up to $120 allowance	up to $50	

Note: "Up to" reflects the Maximum payable for the particular Covered Service.

EXHIBIT B: VISIONS BENEFITS SCHEDULE

As of January 1, 2019:

Materials Only:

Benefit	In-Network	Out-of-Network	Benefit Frequency
VISION MATERIALS			
Standard Plastic Lenses			12 months
Single Vision	$25 Co-payment	up to $30	
Bifocal	$25 Co-payment	up to $50	
Trifocal	$25 Co-payment	up to $70	
Lenticular	$25 Co-payment	up to $70	
Frames	$0 Co-payment, up to $130 retail allowance	up to $91	24 months
Contact Lenses *(only one option available per Benefit Frequency)*			12 months
Conventional	$0 Co-payment, up to $130 allowance	up to $130	
Disposable	$0 Co-payment, up to $130 allowance	up to $130	
Medically Necessary	Paid in full	up to $210	
Lens Options			12 months
Standard Progressive Lenses (add on to Bifocal)	$90 Co-payment	up to $50	
Premium Progressive Lenses (add on to Bifocal)	$90 Co-payment, up to $120 allowance	up to $50	

Note: "Up to" reflects the Maximum payable for the particular Covered Service.

EXHIBIT C: PARTICIPATING EMPLOYERS (CONTROL GROUP 8)

The following is a list of Employer(s) that are participating in this Midwest Dental Employee Vision Benefit Plan (Control Group 8 - Lake Chautauqua Dental, P.C.):

Employer:	**Federal Tax Identification Number:**
Lake Chautauqua Dental, P.C.	47-3946086

EXHIBIT D: INSURANCE POLICY AND CERTIFICATE OF INSURANCE

The Insurance Policy and Certificate of Insurance is attached to this Exhibit D and incorporated into this Plan.