CBA Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

FIRST LIGHT TECHNOLOGIES

Dental and Vision Plan
Summary Plan Description

Effective: April 1, 2009
Revised: August 1, 2017

FIRST LIGHT TECHNOLOGIES
DENTAL AND VISION PLAN

INTRODUCTION

This is a summary of the First Light Technologies Dental and Vision Plan (the "Plan").

This booklet is provided to help you understand how the Plan works. It highlights what types of expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan.

First Light Technologies is sponsoring this self-funded ERISA welfare plan for First Light Technologies which provides dental and vision benefits for all covered employees and dependents.

Each covered employee is entitled to the benefits outlined in this Plan Document. To obtain benefits from the Plan, the covered person must ultimately submit a diagnostic bill from the provider to the Contract Administrator, Comprehensive Benefits Administrator, Inc. dba CBA Blue, for processing. This claim submission is required for reimbursement to the employee or direct payment to the service provider by the First Light Technologies Dental and Vision Plan.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, the Contract Administrator (the third party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan document, which is also the Summary Plan Description within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

A clerical error will neither invalidate the employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

Comprehensive Benefits Administrator, Inc. dba CBA Blue, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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GENERAL INFORMATION

Plan Name: First Light Technologies Dental and Vision Plan

Plan Sponsor/Plan Administrator: First Light Technologies
212 Ideal Way
Poultney, VT 05764
(802) 287-4195

Plan Number: 510 (administered in conjunction with the Wrap Plan Document)

Group Number: 50693

Plan Covered: Dental and Vision

Federal Identification Number: 03-0344799

Plan Effective Date: April 1, 2009

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Plan Revision Date: August 1, 2017 – This document replaces the previous Dental and Vision Plan Document in its entirety. All claims incurred prior to August 1, 2017 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator and Pre-Determination Administrator:
Comprehensive Benefits Administrator, Inc. dba CBA Blue
P.O. Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

Agent for Legal Process: First Light Technologies

Contributions: The Plan is contributory.

Eligibility Requirements: All active full-time employees regularly performing at least thirty (30) hours of service per week.

Dependent Children's Coverage: Married or unmarried dependent children up to twenty-six (26) years of age.

Eligibility Date: First of the month following date of hire.

Termination Date: See "Termination of Benefits" section for details.

First Light Technologies
Schedule of Dental Benefits

Benefit	
Class 1 – Diagnostic/Preventive Care	100% of the first $250 per calendar year; then 75% of the next $1,750 per calendar year.
Class 2 – Basic Care	
Class 3 – Major Care	
Class 4 – Orthodontic Care (only for dependent children age 6 through 19)	50% to a maximum of $1,500 per lifetime

NOTE:

1. Please see the "Covered Dental Expenses" section for further details.
2. This Plan is participating with the Dental Blue®and Dental GRID preferred provider dental network. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
3. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.

First Light Technologies
Schedule of Vision Benefits

Benefit	
Routine Eye Examinations	100% of the first $200 per calendar year; then 75% of the next $200 per calendar year. Exams are limited to 1 every 12 months. Materials are limited to every 24 months.
Frames	
Contact Lenses	
Single Vision Lenses	
Bifocal Vision Lenses	
Trifocal Vision Lenses	
Lenticular Vision Lenses	

The covered person is only allowed one (1) set of frames/lenses (excluding contact lenses) in any 24 month period.

NOTE:

1. All Plan benefits are subject to reasonable and customary allowances.

GENERAL PROVISIONS

PLAN ENROLLMENT

Eligibility: Only employees who satisfy the eligibility requirements set forth in the "General Information" section are eligible for coverage under this Plan. The dependent(s) of a covered employee will become eligible for coverage on the date of the employee's eligibility for coverage or on the date which the employee acquires the dependent.

If an employee and spouse are both eligible for coverage as employees under the Plan, only one (1) will be eligible to enroll dependent(s). Also, an employee cannot be covered as an employee and a dependent.

Plan Enrollment: To become covered under the Plan, an employee must enroll themselves and/or their dependents for coverage within thirty (30) days of the eligibility date. The employee and dependents will be enrolled when a benefit enrollment form is completed, signed, and delivered to the employer within the time limit. Should the enrollment occur more than thirty (30) days following the eligibility date, the employee and/or dependents will only be eligible to enroll during the annual open enrollment period described below or, in certain circumstances, during a special enrollment period.

Annual Open Enrollment Period: There will be an annual open enrollment period during the one (1) month period preceding the Plan's anniversary date. The effective date of coverage will be the Plan's anniversary date.

Special Enrollment Periods: Individuals are eligible for special enrollment for the following reasons:

1. If an employee acquires a dependent through marriage, birth, adoption, or placement for adoption, the dependent (and if not otherwise enrolled, the employee and eligible dependents) may be enrolled under this Plan. The request to enroll must be within thirty (30) days of the event. If enrollment is not requested within thirty (30) days following the event, the dependents will only be eligible to enroll during the annual open enrollment period. The effective date of coverage for dependents and/or employees enrolling during a special enrollment period will be the date of the event.
2. If an employee declines enrollment in the Plan for themselves or their dependents because the employee or dependents have other health coverage, the employee may in the future be able to enroll themselves and/or their dependents in the Plan, provided they are otherwise eligible for coverage under the terms of the Plan, they meet certain conditions including any one of those set forth below and they request enrollment within thirty (30) days of that condition being satisfied:
    - when enrollment was declined under this Plan for employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under another health plan, and COBRA continuation coverage under that other plan has since been exhausted; or

- if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, employer contributions toward the other coverage have ceased, regardless of whether coverage under the other employer's plan has terminated; or
- if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
    a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
    b. the employee and/or dependent having reached their lifetime benefit maximum under the other coverage; or
    c. the employee and/or dependent moving out of an HMO service area if HMO coverage terminates for that reason and, no other plan options are available to the employee/dependent; or
    d. the other plan ceasing to offer coverage to the group of similarly situated individuals that include the employee and/or dependent; or
    e. the dependent losing dependent status per plan terms; or
    f. the other plan terminating a benefit package option and no substitution is offered.

The effective date of coverage will be the date following the date of the loss of the other coverage. The Plan's waiting period will not be applied.

3. If an employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or if the employee or dependent becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP, the employee may request to be enrolled in this Plan. The employee's request to enroll must be made within sixty (60) days of the date on which the employee or dependent either (a) loses eligibility under Medicaid or CHIP or (b) becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP. The effective date of coverage for such employee and/or dependent will be the first day of the month following the employee's request to enroll in this Plan.

Qualified Medical Child Support Orders: If an employee is required to provide benefits for his dependent child under the direction of a court order and the employee is not enrolled in the Plan, the employee may enroll himself and his dependent child provided enrollment is requested within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

COORDINATION OF BENEFITS (COB)

Should a covered person be enrolled in this Plan while enrolled in any other plan providing similar benefits, Coordination of Benefits (COB) rules control whether benefits are payable under this Plan before those of the other plans. The benefits payable under this Plan will not be reduced where the COB rules provide that this Plan pays first. The benefits payable under this Plan may, however, be reduced where the COB rules provide that another plan pays first. In any case, the total of all benefits payable under all plans will not exceed 100% of the allowable expenses, and no plan will pay more than it would otherwise pay in the absence of the COB rules.

If a plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

Even if a plan does have its own COB rules, the first of this Plan's following COB rules to apply will determine which of the plans is primary:

1. Non-Dependent/Dependent - Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.

2. Dependent Child/Parents Not Separated or Divorced - If a dependent child is covered under the plans of both the child's parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.

3. Dependent Child/Separated or Divorced Parents - Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child's health care costs:

    a) the plan under which the child is covered as a dependent of the custodial parent will pay first;
    b) the plan under which the child is covered as a dependent of the custodial parent's spouse will pay second; and
    c) the plan under which the child is covered as a dependent of the non-custodial parent will pay third.

4. Active/Inactive Employee - Any plan under which the covered person is covered as an active employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that employee's dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage - Any plan under which the covered person is covered as an employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the plan which has covered the eligible person for the longest period of time will pay first; the plan which has covered the eligible person for the shortest period of time will pay last.

Right to Receive and Release Needed Information: The Plan may release or receive any information needed to enforce this provision. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

Right to Make Payments: Should another plan provide benefits which should have been paid by this Plan, the Plan has the right to make payment to the other plan directly. That payment will satisfy the obligation of this Plan.

Right to Recovery: The Plan has the right to recover from the covered person any overpayment made if the Plan was not made aware of the other available benefits.

Coordination with Other Liability: This Plan will pay benefits secondary to the covered person's personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical payments may be made for expenses resulting from or in connection with an accidental injury.

TERMINATION OF BENEFITS

An employee's and/or a dependent's coverage under the Plan will terminate:

1. on the date the Plan terminates; or

2. on the date an employee withdraws from the Plan; or

3. on the date which an employee is terminated, unless continuation coverage, as provided herein, is elected; or

4. on the date a dependent withdraws from the Plan or a dependent ceases to meet the definition of a dependent as defined herein or dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or

5. on the date when an employee or dependent enters the military, naval, or air force of any country or international organization on a full-time, active-duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or

6. on the last date of the period for which contribution has been made if the employee fails to make any required contribution.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered employees and their dependents must be offered the right to continue coverage for up to twenty-four (24) months. The employer may charge 102% of the applicable premium, unless specified otherwise, provided the length of the military leave is longer than thirty (30) days. However, on the date that the employee completes his active duty and returns to full-time employment, the employee and his eligible dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the employee's or dependent's coverage which were in affect before the active military duty leave will continue to apply.

REINSTATEMENT OF COVERAGE

Should an employee return to active full-time employment within ninety (90) days of the date previous employment terminated, the waiting period will be waived. Otherwise, all provisions applicable to a new employee will apply.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect to continue coverage under the Plan when their coverage terminates due to a "qualifying event." Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the Plan and the employee's covered dependents. These rights are protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Contract Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The employee has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.

The employee's spouse has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.
3. The employee's death.
4. The employee's divorce or legal separation.
5. The employee becomes entitled to Medicare benefits (Part A, Part B or both).

The employee's dependent children have the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee's termination of employment for reasons other than gross misconduct.
2. The employee's retirement or reduction in hours of employment.
3. The employee's death.
4. The employee's divorce or legal separation.

5. The employee becomes entitled to Medicare benefits (Part A, Part B or both).

6. The employee's dependent child ceases to be an eligible dependent as such term is defined in the Plan.

Similar rights may apply to certain retirees, spouses, and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Contract Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Contract Administrator of the qualifying event within thirty (30) days of any of these events on the form provided by the Contract Administrator to the employer.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), the qualified beneficiary must notify the Contract Administrator. The Contract Administrator must be notified in writing within sixty (60) days after the qualifying event occurs.

Once the Contract Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Contract Administrator must notify the qualified beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Contract Administrator is notified of a qualifying event.

The qualified beneficiary has sixty (60) days from the date of the written notice or qualifying event, whichever is later, to notify the Contract Administrator of their decision to elect COBRA continuation of coverage. To receive COBRA continuation of coverage, no evidence of insurability will be required, but a monthly premium will be charged. If continuation of coverage is not elected on a timely basis, group health insurance coverage will end.

If Medicare entitlement occurs prior to a qualifying event, then COBRA begins on the date of Medicare entitlement.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the day following the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA coverage will end thirty-six (36) months from the date the employee became entitled to Medicare (but the covered employees' maximum coverage period will be eighteen (18) months). This extension is available only if the covered employee becomes entitled to Medicare within eighteen (18) months before the termination of employment or reduction of hours occurs.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and the Contract Administrator is notified in a timely fashion, the employee and his covered dependents can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The qualified beneficiary must make sure that the Contract Administrator is notified in writing of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, then the beneficiary must notify the Plan within thirty (30) days of determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If the employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies, gets divorced or legally separated. This extension may be available to a spouse or dependents if the former employee enrolls in Medicare. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the qualified beneficiary must make sure that the Contract Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event.**

In no event will COBRA coverage continue beyond thirty-six (36) months from the date of the original qualifying event.

Monthly Premium

1. The monthly premium will be 102%, unless specified otherwise, or if applicable 150% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA continuation of coverage.

2. The initial premium payment is due within forty-five (45) days of electing COBRA continuation of coverage. The payment must cover all premiums due from the date of the qualifying event.

3. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Termination of COBRA continuation coverage

COBRA continuation of coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its employees.

2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.

3. The person who has elected COBRA coverage becomes enrolled in Medicare benefits (Part A, Part B or both). COBRA coverage will terminate on the first day of the person's birthday month. Should the person's birthday be on the first day of the month, then COBRA coverage will terminate on the first day of the month prior to the person's birthday.

4. The qualified beneficiary who has elected COBRA coverage becomes covered under another group health and/or dental plan.

5. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

The covered employee does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to the covered employee's eligibility for coverage; the Plan Administrator reserves the right to terminate the covered employee's coverage retroactively if he or she is determined to be ineligible.

Keep Plan Informed of Address Changes

In order to protect the participant's family's rights, the participant should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

PLAN DETAILS

Dental Blue®Network Program

The Plan includes access to CBA Blue's preferred dental provider network, Dental Blue®, in order to obtain discounts from participating providers for covered dental care. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

Dental GRID Network Program

The Plan includes access to the Dental GRID network which links participating Blue Cross and Blue Shield dental providers in several states into one overall national dental network with broad access to participating dentists. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

Pre-Determination of Dental Benefits

Pre-determination of benefits means a review by the Contract Administrator of a dentist's description of planned treatment and expected charges including those for diagnostic x-rays.

It is recommended that a treatment plan be submitted to the Contract Administrator before a course of treatment begins which can reasonably be expected to involve extensive dental work in excess of **$400**. Pre-determination of benefits does not guarantee payment.

All pre-determinations should be mailed to:

CBA Blue
P.O. Box 9350
South Burlington, VT 05407-9350

COVERED DENTAL EXPENSES

Covered dental expense means the maximum allowable charge made by a dentist for the performance of a dental service covered by the dental portion of the Plan, provided such a service is performed by or under the direction of a licensed dentist for necessary care of the teeth.

The total amount payable for covered dental expenses incurred by the employee and each covered dependent(s) in any one (1) calendar year for dental services will in no event exceed the maximums shown in the Schedule of Benefits.

Class 1: Diagnostic and Preventive Care

Oral Examinations (includes initial and periodic)
Cleanings (prophylaxis)
Fluoride Treatments - only for dependent children under age 15
Sealants – only for dependent children under age 14
Space Maintainers – for dependent children only, and only for missing primary teeth
X-rays and Diagnostics:
- Full Mouth and Panoramic
- Bitewings
- Individual Teeth

Emergency Palliative Treatment
Professional visits after hours

Class 2: Basic Care

Periodontal Cleaning
Fillings
Extractions
Oral surgery – includes the removal of bony impacted teeth
General and local anesthesia, Analgesia
Injectable antibiotics only
Endodontics
Periodontics
Repair of prosthetic appliances
Occlusal Adjustments performed in conjunction with periodontal surgery
Occlusal Guards for treatment of periodontal disease only, including adjustment within 6 consecutive months
Stainless Steel Crowns – only when tooth cannot be restored with filling material, limited to primary teeth only
Temporary crowns only for dependent children under age 16

Class 3: Major Care

Crowns (except for stainless steel)
Inlays
Onlays
Bridges – including Maryland Bridge
Dentures, Full or Partial – includes adjustments and relining within 6 months of installation
Posts – cast post and core, steel post and core, cast dowel pin
Temporary Crowns (for covered persons age 16 or over) or Bridges – expense for temporary crown or bridge will be deducted from total cost of the permanent bridge
Implants

Class 4: Orthodontic Care (only for dependent children age 6 through 19)

Diagnosis (includes initial exam)
Related X-Rays
Study Models
Extraction of teeth for active orthodonture
Active Orthodontic Treatment
Retention Treatment

GENERAL DENTAL EXCLUSIONS AND LIMITATIONS

Following is a list of services/supplies that will not be paid by the Plan:

1. Services and supplies incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.

2. Services for disease or injury sustained as a result of war, or participation in riot or civil disobedience or while committing or attempting to commit a criminal act or engaging in an illegal activity, suicide, or intentionally self-inflicted injuries.

3. Services for which a charge is not usually made, for a charge that would not be made if the employee had no dental coverage, or for services rendered by a person to his/her own family members.

4. Unnecessary care, treatment, surgery, or solely for cosmetic reasons, except as provided herein.

5. Confinement in a hospital.

6. Services and supplies for which the employee or their family members are not legally required to pay.

7. Services and supplies in excess of the maximum allowable benefit, as determined by the Plan.

8. Unnecessary care, treatment (including those not customarily performed for that particular dental condition), or dental procedures performed to characterize or personalize dentures, bridges, or crowns.

9. Replacement of a lost, missing, or stolen prosthetic device or other device or appliance (except space maintainers); or a bridge or denture which meets or can be made to meet generally accepted dental standards or for a duplicate set of dentures or appliances; or for the upgrading of a replacement appliance, crown, inlay, onlay, or fixed bridge (an upgrade may be chosen, however, the Plan will consider the cost of the necessary replacement).

10. Instruction in oral hygiene, plaque control, dietary control, or for the completion of any forms or failure to keep any scheduled appointment.

11. Any service or supply which is not furnished by a dentist, except a service performed by a dental hygienist working under the supervision of a dentist and x-rays ordered by a dentist.

12. Appliances, restorations, or procedures (except full dentures) for altering vertical dimension, restoring or maintaining occlusion, splinting, bite registration, bite analysis, replacement of tooth surface lost by abrasion or attrition, correcting congenital or developmental malformations (including replacement of congenitally missing teeth), myofunctional therapy, correction of harmful habits (except for occlusal guards for treatment of periodontal disease), or for the diagnosis or treatment of Temporomandibular Joint Dysfunction (TMJ).

13. Procedures, services, or appliances (including prosthodontics) initiated or provided prior to the covered person's effective date of coverage or following the date the covered person's coverage terminates (**except** inlays, onlays, and crowns which are finally inserted within thirty (30) days after termination of coverage will be covered).

14. Treatments or procedures which are experimental whether for diagnosis or treatment of any sickness or injury as determined by the American Dental Association or the appropriate dental specialty society or that do not meet common dental standards.

15. Services that are deemed to be medical services or for services and supplies received from a hospital unless otherwise provided herein. Benefits for the surgical removal of bony impacted teeth are not covered under the First Light Technologies Medical Plan and therefore will be considered as primary under this Plan. If the covered person is covered under any other Medical Plan and that Medical Plan covers the surgical removal of bony impacted teeth, this Dental Plan will pay secondary to the other Medical Plan. If the other Medical Plan does not cover the surgical removal of bony impacted teeth, this Dental Plan will be considered primary.

16. Replacement of any prosthetic appliance, crown, fixed bridge, inlay, or onlay restoration as medically necessary.

17. Veneers or similar overlays on bridges placed on the twelve (12) molar teeth or for overlays or non-restorative bonding or appliances to treat bruxism.

18. Prescription drugs or medications, except as provided herein.

19. Over-the-counter home fluoride treatments (i.e. omni gel).

20. Tooth bleaching unless done to restore color on a tooth which previously had a root canal.

21. Services which have not been completed. (Inlays, onlays, crowns, bridges, and dentures will be considered completed on the date prepared and final impressions are taken.)

CLAIM FILING PROCEDURES

Written notice of the employee or their dependent's claim (proof of claim) must be given to the Contract Administrator as soon as is reasonably possible but within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the employee's responsibility to inform his provider(s) of this claim submission time limit.

Filing a Dental and Vision Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the employee's name, claimant's name, claimant's address and Plan number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all dental and vision claims to:

CBA Blue
P.O. Box 9350
South Burlington, VT 05407-9350

[Should the employee have any questions, please feel free to call or write to the Contract Administrator.]

CLAIM REVIEW PROCEDURES

I. Failure to Follow Pre-Service Claim Procedures:

In the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a Claim involving Urgent Care) following the failure. This notification will be oral unless written certification is requested by the claimant or authorized representative. This section shall only apply in the case of a failure that:

1. Is a communication by a claimant or an authorized representative of a claimant that is received by the Pre-Certification Administrator; and

2. Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested.

II. Timing of Notice of Benefit Claim Determinations:

(a) Provisions Applicable to All Benefits Under the Plan.

(i) The various time periods set forth in this Section II within which benefit determinations must be made shall begin at the time a claim is filed in accordance with the Plan's procedures without regard to whether all the information necessary to make a benefit determination accompanies the filing.

(ii) If any period of time set forth in this Section II is extended because of a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(b) Additional Provisions Applicable to Health Benefits.

(i) Urgent Care Claims: In the case of a Claim involving Urgent Care, the Contract Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim by the Contract Administrator, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Contract Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Contract Administrator, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Notification of any Adverse Benefit Determination will be made in accordance with the Written Denial provisions set forth below. The Contract Administrator will notify the claimant of the Plan's benefit

determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Contract Administrator's receipt of the specified information, or

2. The end of the period afforded the claimant to provide the specified additional information.

(ii) Concurrent Care Decisions: If an ongoing course of treatment to be provided over a period of time or number of treatments has been approved by the Plan, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Contract Administrator will notify the claimant, in a manner in accordance with the Written Denial provisions set forth below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical exigencies, and the Contract Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Contract Administrator, provided that any such claim is made to the Contract Administrator at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse determination concerning a request to extend the course of treatment, whether involving Urgent Care or not, shall be made in accordance with the Written Denial provisions set forth below, as appropriate.

(iii) Pre-Service Claim: In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Contract Administrator. The period may be extended one time by the Plan for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Written Denial provisions set forth below.

(iv) Post-Service Claim: In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not more than thirty (30) days after receipt of the claim. This period may be extended one time by the Contract Administrator for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(c) Additional Provisions Applicable to Disability Benefits. In the case of a claim for disability benefits, the Contract Administrator shall notify the claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the claim by the Contract Administrator. This period may be extended by the Plan for up to thirty (30) days, provided that the Contract Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial forty-five (45) day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first thirty (30) day extension period, the Contract Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional thirty (30) days, provided that the Contract Administrator notifies the claimant, prior to the expiration of the first thirty (30) day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. In the case of any extension under this paragraph, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least forty-five (45) days within which to provide the specified information.

(d) Additional Provisions Applicable to Benefits other than Health Benefits and Disability Benefits. If a claim for benefits other than health benefits or disability benefits is wholly or partially denied, the Contract Administrator shall notify the claimant of the Adverse Benefit Determination within a reasonable period of time not to exceed ninety (90) days after receipt of the claim by the Contract Administrator, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If the Contract Administrator determines that such an extension is required, written notice (in accordance with the Written Denial provisions set forth below) of the extension shall be provided to the claimant prior to the termination of the ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period. The notice of the extension provided to the claimant shall indicate the circumstances requiring an extension and the date by which the Contract Administrator expects to render the benefit determination.

III. Written Denial Provisions

(a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a claimant with written or electronic notification of any determination of a claim. In the case of an Adverse Benefit Determination, the notification shall set forth in a manner calculated to be understood by the claimant:

(i) The specific reason(s) for the denial;

(ii) Specific references to pertinent Plan provisions upon which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim, and an explanation of why such material or information is necessary;

(iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(b) Additional Provisions Applicable to Health Benefits and Disability Benefits. In the case of an Adverse Benefit Determination concerning health benefits or disability benefits, the notification shall also set forth in a manner calculated to be understood by the claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination (a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request);

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) In the case of an adverse determination concerning a Claim involving Urgent Care, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above in this Section III may be provided to the claimant orally, provided that a written or electronic notification is furnished to the claimant not later than three (3) days after the oral notification.

IV. Appeal of Adverse Benefit Determinations

(a) Provisions Applicable to All Benefits under the Plan.

(i) Each claimant shall be afforded a full and fair review of any Adverse Benefit Determination.

(ii) Each claimant may appeal an Adverse Benefit Determination within one hundred eighty (180) days (sixty (60) days in the case of an Adverse Benefit Determination relating to benefits other than health benefits or disability benefits) following receipt of notification of the Adverse Benefit Determination.

(iii) In connection with such review, the claimant shall have the opportunity to submit any written comments, documents, records or other information the claimant believes is relevant.

(iv) In connection with such review, the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's appeal.

(v) The review of the Adverse Benefit Determination shall take into account all comments, documents, records and other information submitted by the claimant that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(b) Additional Provisions Applicable to Health Benefits and Disability Benefits.

(i) The review shall not afford deference to the initial Adverse Benefit Determination.

(ii) The review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the review, nor a subordinate of such individual.

(iii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the person conducting the review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of consultation in accordance with the previous sentence shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual.

(iv) The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided to the claimant.

(v) In the case of a Claim involving Urgent Care, an expedited review process will be provided, pursuant to which a request for an expedited appeal to an Adverse Benefit Determination may be submitted orally or in writing by the claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

V. Timing of Notice of Benefit Determination Following Review

(a) Provisions Applicable to All Benefits under the Plan.

(i) The various time periods set forth in this Section V within which the review of an Adverse Benefit Determination must be completed shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a determination on review accompanies the filing.

(ii) If any period set forth in this Section V is extended as permitted herein due to a claimant's failure to submit information necessary to decide a claim, the period for making the determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(b) Additional Provisions Applicable to Health Benefits.

(i) Urgent Care Claims: In the case of a Claim involving Urgent Care, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan.

(ii) Pre-Service Claims: In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(iii) Post-Service Claims: In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination, of the plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than sixty (60) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

(c) Additional Provisions Applicable to Benefits other than Health Benefits. In the case of an appeal of an Adverse Benefit Determination other than one relating to health benefits, the Contract Administrator shall notify the claimant of the benefit determination on review within a reasonable period of time, but not later than sixty (60) days (forty-five (45) days in the case of a disability benefit) after receipt of the claimant's request for review, unless the Contract Administrator determines that special circumstances such as the need to hold a hearing require an extension of time for processing the claim. If the Contract Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial period. In no event shall such extension exceed a period of sixty (60) days (forty-five (45) days in the case of disability benefits) from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

VI. Notification of Benefit Determination

(a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a claimant with a written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the claimant:

(i) The specific reason(s) for the adverse determination;

(ii) Reference to the specific Plan provisions on which the benefit determination is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

(b) Provisions Applicable to Health Benefits and Disability Benefits. In the case of an Adverse Benefit Determination on review concerning health benefits or disability benefits, the notification shall also set forth, in a manner calculated to be understood by the claimant:

(i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination (a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request);

(ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

MISCELLANEOUS PROVISIONS

Discharge: Any payment by the Contract Administrator in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the payments so made.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all employees, dependents, and beneficiaries.

Except for functions reserved by the Plan to the Employer or the Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. In accordance with Sec. 503 of Title I of ERISA, the Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary (including, but not limited to, the denial of certification of medical necessity of hospital or medical treatment). In exercising its fiduciary responsibilities, the named fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful plan terms. The named fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Federal Guidelines for a Plan Subject to the Employee Retirement Income Security Act of 1974 (ERISA): This Plan will comply with all Federal law and guidelines relative to welfare benefit plans under ERISA. These Federal laws and guidelines will supersede any provisions and terminology contained herein which may be to the contrary.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered employee's and/or dependent's coverage will become effective as of the date of such amendment, provided coverage is in effect on the date of such amendment. Any amendment to the Plan providing a decrease in the amount of a covered employee's and/or dependent's coverage will begin on the effective date of such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver Plan benefits. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another plan, the Plan Administrator may, release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Contract Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to Contract Administrator such information as may be required to implement this provision in accordance with HIPAA Privacy Regulations.

Right of Recovery: Whenever the Contract Administrator has allowed benefits to be paid by this Plan which have been paid or should have been paid by any other plan, or which were erroneously paid, the Contract Administrator will have the right to recover any such excess payments from the appropriate party.

Right to Amend the Plan: The President, Vice President, Treasurer, Chief Financial Officer, Chief Executive Officer, Controller, or head of the Human Resources/Personnel Department, as authorized by the Plan Sponsor, has the authority to amend the Plan Document, modifying any of the provisions herein, or terminating the Plan at any time without the consent of or notice to any covered person hereunder. The Plan may be amended, modified, or terminated as required by Plan utilization, costs, market forces, federal legislation, or other general business concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all covered persons.

Should the Plan be amended and, thereby, terminated, the Plan Administrator will provide for:

First: Payment of benefits to each covered person of all covered expenses for services which were incurred while the Plan was in effect.

Second: Payment of expenses incurred in the liquidation and distribution of the Plan and any payments due to the Plan Administrator.

Third: Direct disposition of all assets, if applicable, held in the Plan to covered persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

Subrogation, Reimbursement & Third Party Recovery Provision:

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Participant(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party.
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
    c. Any policy of insurance from any insurance company or guarantor of a third party.
    d. Workers' compensation or other liability insurance company.
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

1. Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

    a. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
    b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
    c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
    d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

1. It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
    f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
    g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
    h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

2. If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

1. In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

The Use and Disclosure of Protected Health Information:

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose protected health information (PHI) (as such term is defined in the HIPAA regulations) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"). Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as permitted or required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. Except for the uses and disclosures permitted or required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. For Purposes of This Section, First Light Technologies Is the Plan Sponsor

The Plan has received a certification from the Plan Sponsor that the separate Plan documents (if any) have been amended to incorporate the provisions set forth in D, below.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- ensure that any agents, including a subcontractor, 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;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual in accordance with HIPAA;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual in accordance with HIPAA;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures in accordance with HIPAA;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- 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); and
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information.

E. 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:

- the benefits manager; and
- staff designated by the benefits manager.

The following employees, classes of employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to payment under, health care operations of, or other matters pertaining to the administration of the Plan in the ordinary course of business:

President

Finance Manager

Business Manager

Staff designated by the President

F. Limitations of PHI Access and Disclosure

The Plan may disclose PHI to the Plan Sponsor (via the persons described in section E), and the Plan Sponsor may use and further disclose such PHI, only when the Plan Sponsor is either: (i) performing plan administration functions that the Plan Sponsor performs for the Plan or (ii) acting on behalf of the Plan; provided that the Plan Sponsor may only use or disclose PHI to the same extent as would be permitted by the Plan under the HIPAA regulations.

G. Noncompliance Issues

If Plan Sponsor personnel do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

H. Security Requirements

The security rule requires plans to comply with four (4) general requirements. The Plan must:

- ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic protected health information;
- protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, the employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

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

3. 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.

4. File suit in a Federal court if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110 per day until the employee receives the materials.

5. File suit in a State or a Federal court if the employee is improperly denied a welfare benefit in whole or in part. The employee must receive a written explanation of the reason for the denial. The employee has the right to have the Plan review and reconsider the employee's or his dependent's claim.

6. Seek assistance from the U.S. Department of Labor or file suit in a Federal court if:

    A. Plan fiduciaries misuse the Plan's money. In addition to creating rights for Plan participants, ERISA imposes duties to the people who are responsible for this operation of the Plan. The people who operate the employee's Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the employee and other Plan participants.

    B. The employee is discriminated against for asserting the employee's rights. The employee's employer may not fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising the employee's rights under ERISA.

The court will decide who should pay court costs and legal fees. Should the employee be successful, the court may require the other party to pay the employee's legal costs and fees.

Should the employee have any questions about this statement or about the employee's rights under ERISA, the employee should 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.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Active Service: An employee will be considered in active service with the employer on a day which is one of the employee's scheduled work days if the employee is performing in the customary manner all of the regular duties of his/her employment with the employer on that day either at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A regular vacation day, properly scheduled in accordance with normal practices and policies of the employer, will qualify as a scheduled work day for purposes of this definition.

Adverse Benefit Determination: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Claim for benefits: A request for a Plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing benefit claims. This includes any Pre-Service Claims and any Post-Service Claims.

Claim involving Urgent Care: Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:

(i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

Except as set forth in the next paragraph, whether a claim is a Claim involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a physician with knowledge of the claimant's medical condition determines is a Claim involving Urgent Care shall be treated as Claim involving Urgent Care.

Coinsurance: The percentage of charges for covered expenses that a covered person is required to pay under the Plan.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. Reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered employees and/or providers;

2. Remitting benefit payments for covered expenses under the Plan to covered employees and/or providers;

3. Reviewing all claim appeals.

Contributory Coverage: Group Plan benefits for which an employee enrolls and agrees to make any required contributions toward the cost of coverage.

Covered Person: A covered employee or a covered dependent as determined under the applicable Plan provisions.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Deductible: The amount of covered expenses the covered employee must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed Doctor of Dentistry and a Dental professional or practitioner, who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Dentistry, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Doctor of Dentistry.

Dependent:

1. The lawful spouse of an eligible employee; or

2. the unmarried child of an eligible employee who has not attained their twenty-sixth (26^{th}) birthday.

The term “lawful spouse,” as used above, means an eligible employee's same or opposite-sex spouse, provided that such individual is legally recognized as the eligible employee's spouse in any jurisdiction (such as a State or foreign country), and even if the individual is not recognized as the eligible employee's spouse in the employee's State of residence.

The word “child”, as used above, will include an eligible employee’s natural child, a legally adopted child (including a child in the custody of the employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child or a child for whom legal guardianship has been granted, all of whom are dependent upon the eligible employee for support and maintenance but excludes a child who is eligible for employee coverage under this Plan.

Should an employee have a child covered under the Plan who reaches the age at which the child would otherwise cease to be a covered person and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the employee has, within thirty-one (31) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein..

Dependent Coverage: Group Plan benefits extended to the dependent(s) of a covered employee.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Effective Date of Coverage: The date an employee and/or his dependent(s) become eligible to enroll in the Plan.

Employee: Any employees who qualify for employee coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of an employee does not include independent contractors, contingent workers, or leased employees.

Employee Coverage: Group dental and vision benefits provided under the Plan on behalf of a covered employee.

Employer: The Plan Sponsor who provides employment to the covered employees.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

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

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

- quality assessment;
- 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 information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- 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);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- 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;
- 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 HIPAA's administrative simplification requirements, or
  (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Hospital: A duly licensed, if required, and legally constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care, and treatment of sick or injured persons on an inpatient and/or outpatient basis and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged.

Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

Illness: Sickness or disease which results in the incurrence, by a covered person, of expenses for dental care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person whose illness is the basis of claim is covered under the Plan. Pregnancy will be treated as any other illness.

Injury: Accidental bodily harm.

Inpatient Basis: Hospital confinement, including one (1) or more days of confinement for which a room and board charge is made by a hospital.

Maximum Allowable Benefit: An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the person is responsible for the difference.

Maximum Calendar Year: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in one (1) calendar year. See amounts on the Schedule of Benefits.

Maximum Lifetime Benefits: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in a lifetime. See amounts on the Schedule of Benefits.

Non-Contributory Coverage: Group Plan benefits for which the employee enrolls and for which the employee or the employee's dependent is not required to make a contribution toward the cost of coverage.

Non-Dependent/Dependent: An employee covered under this Plan (non-dependent) who is also covered under another group dental plan as a dependent.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

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

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and
- 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).

Pre-Service Claim: Any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Physician: A duly licensed Doctor of Medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Medical Doctor.

Plan: The First Light Technologies Dental and Vision Plan as described herein.

Plan Administrator: First Light Technologies

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Document: The master contract which describes the terms of coverage and association between the Contract Administrator and the Plan Sponsor.

Plan Sponsor: The company sponsoring the benefit Plan described herein. (First Light Technologies)

Post-Service Claim: Any claim for a benefit under the Plan that is not a Pre-Service Claim.

Prior Plan: The prior dental and vision plan offered by the Plan Sponsor.

Pronouns: Masculine pronouns used herein apply to both sexes.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

    (a) that identifies the individual; or

    (b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and

- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Protected Heath Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Qualified Beneficiary: Any covered person who loses coverage as a result of a qualifying event described in the "Extension of Benefits" section. These beneficiaries are:

1. covered employees (and their spouses and dependent children) who have been terminated for reasons other than the covered employee's gross misconduct, or have had their hours reduced (resulting in a loss of coverage);

2. widowed spouses and dependent children;

3. divorced or legally separated spouses and their dependent children;

4. Medicare ineligible spouses and their dependent children;

5. a covered dependent child who no longer meets the Plan's definition of a covered dependent child;

6. a child born to, or placed for adoption with the covered employee during the period of COBRA coverage.

Reasonable and Customary Allowance (R&C): A maximum allowable charge for each covered medical and dental service provided for under the Plan, as established for this Plan, solely by a national firm. The following is used as a guide: This allowance schedule is intended to include all charges provided, in the geographical area where the covered expense is incurred, by properly licensed medical and dental care providers, and which do not exceed the usual fees charged for comparable services.

Relevant: In the context of whether a document, record or other information shall be considered "relevant," means the following: a document, record, or other information

(i) relied upon in making the benefit determination;

(ii) submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(iii) demonstrating compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants in making the benefit determination; or

(iv) constituting a statement of policy of guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In no event should the provisions of this Claim Review Procedures section be interpreted to require any claimant to file more than two (2) appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA.

Totally Disabled: A covered person who, because of illness or injury, is unable to engage in any gainful occupation for profit or compensation for which the covered person qualifies by reason of education, training, or experience. In the case of a dependent, the term "occupation" will include the normal activities of a person of the same age or sex.

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Waiting Period: The period of time between the employee's satisfaction of the plan's eligibility requirements and the effective date of coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the First Light Technologies Dental and Vision Plan, is hereby executed at:

Poultney, VT on 8/7/17
(City) (State) (Date)

BY: _____

TITLE: Bus Mgr.