CHRISTIAN BROTHERS
SERVICES

CHRISTIAN BROTHERS EMPLOYEE BENEFIT TRUST

DENTAL PLAN

SUMMARY PLAN DOCUMENT

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INTRODUCTION

Christian Brothers Employee Benefit Trust is a self-funded church plan that serves employers operating under the auspices of the Roman Catholic Church by providing dental benefits to Plan participants. It is understood that the Trust works within the framework of the tenets of the Roman Catholic Church. It is for this reason the Trust does not provide benefits for services that are not consistent with the position of the Church.

The Trust is comprised of Members which are organizations operating under the auspices of the Roman Catholic Church, and are currently listed, or approved for listing, in *The Official Catholic Directory*, published by P.J. Kenedy & Sons. For ease of reference in this Summary Plan Document, these Members are referred to as Employers.

Each of these Members has one or more persons who receive benefits from This Plan. These Participants may include employees, academic employees, members of religious orders, seminarians and secular priests. For ease of reference in this Summary Plan Document, the Participants are referred to as Employees.

We, Us, and Our means the Christian Brothers Employee Benefit Trust Trustees or, alternately, the Plan Administrator for specific duties that have been delegated to the Plan Administrator by the Trustees.

1. PLAN INFORMATION

Plan Name:

Christian Brothers Employee Benefit Trust

Plan Sponsor:

Christian Brothers Major Superiors
c/o Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679

Plan Administrator:

Christian Brothers Services
1205 Windham Parkway
Romeoville, IL 60446-1679
Telephone: 800-807-0100
EIN: 36-3884439

Plan Year:

Christian Brothers Employee Benefit Trust is a Calendar Year Plan.

Agent for Service or Legal Process:

Christian Brothers Employee Benefit Trust
Managing Director, Health Benefit Services
1205 Windham Parkway
Romeoville, IL 60446-1679

Plan Eligibility and Benefits:

See Eligibility Section of this Summary Plan Document to locate a description of dental benefits and eligibility requirements.

How to File a Claim:

See Claim Procedures.

A. Plan Benefits

Plan Benefits are governed by this Summary Plan Document.

B. Plan Interpretation

This Summary Plan Document has been prepared with as much information as is reasonable to help you understand your benefits. However, some terms in This Plan may require interpretation as they apply to a specific situation.

The Plan Administrator has been given the authority and discretion by the Plan Trustees to interpret the terms of This Plan where the Plan's terms need interpretation and to approve certain services in catastrophic cases.

In interpreting the terms of This Plan, the Plan Administrator relies upon commonly accepted industry practices, as well as experts in the healthcare industry, including its various subspecialties.

C. Conformity with State Mandates

The Christian Brothers Employee Benefit Trust is a "church plan" as designated by the Internal Revenue Service and Department of Labor. It is not a group insurance contract within the meaning of state group insurance laws. Therefore, the Christian Brothers Employee Benefit Trust is not subject to the mandated benefit requirements imposed by state group insurance laws. To the extent that state laws other than those applicable to group insurance contracts may legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will conform to the state mandate, unless the mandated benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

D. Conformity with Federal Mandates

The Christian Brothers Employee Benefit Trust is generally subject to the provisions of the Patient Protection and Affordable Care Act. Accordingly, to the extent that Act would legally require the Christian Brothers Employee Benefit Trust to provide a particular benefit, the Christian Brothers Employee Benefit Trust will do so, unless providing the benefit would conflict with the doctrine or tenets of the Roman Catholic Church.

E. HIPAA

The privacy of your health records is protected by specific security and privacy regulations under the Health Insurance Portability and Accountability Act (HIPAA). Under HIPAA, neither the Plan Sponsor nor the Plan Administrator may release Protected Health Information (PHI) to your Employer, spouse, or any other third party unless required by law or unless you authorize the release. The Plan Notice of Privacy Practices describes the Plan's privacy practices and your rights to access your records. The notice is available on the Christian Brothers Services website in the section relating to HIPAA authorization forms at https://www.cbservices.org/hipaa-authorization-forms.html.

2. ELIGIBILITY

You may be eligible to participate in This Plan if you are an Employee who is employed by an Employer that participates in This Plan. If you are eligible to participate in This Plan, your Dependents may also be eligible to participate in This Plan.

A. Who is Eligible

Covered Person means an Employee or Dependent eligible to receive benefits under This Plan.

Employee means an eligible employee of an Employer whose work week meets the minimum requirements as determined by the Employer. In no event can an employee be eligible to participate in This Plan who works fewer than 20 hours in a normal work week.

For an academic employee, Employee includes an academic employee who meets the requirements as determined by the Employer. In no event can an academic employee be eligible for This Plan who teaches less than ½ of a normal work load.

Employee may include members of religious orders, seminarians and secular priests.

Employee does not include temporary employees, employees who do not meet the above criteria, independent contractors, volunteers, etc., whose income from the Employer is not subject to Federal Withholding for wages or FICA, except in case of vowed religious.

Employer means any corporation, establishment, or institution that has fulfilled participation requirements of the Trust:

(1) is operated under the auspices of the Roman Catholic Church, in good standing thereof, and is currently listed, or approved for listing, in *The Official Catholic Directory*, published by P.J. Kenedy & Sons; and
(2) is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986, as amended; and
(3) is organized as a not-for-profit corporation, if the organization is a corporation.

Dependent means:

(1) your Spouse, if not in the Armed Forces and not covered as an Employee;
(2) your natural or legally adopted child under 26 years of age;
(3) a child of your Spouse under 26 years of age; and
(4) a child under 26 years of age for whom you have legal guardianship.

Dependent also includes any child covered under a Qualified Medical Child Support Order or National Medical Support Notice as defined by applicable federal law and state insurance laws applicable to This Plan, provided the child otherwise meets This Plan's definition of a Dependent.

In no event may a Dependent child be covered by more than one Employee.

A covered child, who attains the age at which status as an eligible Dependent would otherwise terminate, may retain eligibility if the Dependent is chiefly reliant upon the Employee for support and maintenance and incapable of self-sustaining employment by reason of Physical Disability. Such condition must start before reaching the age when the child's Dependent status otherwise would terminate. We may ask for proof of incapacity from time to time. If proof is requested and We do not receive the requested information within 90 days, the child will no longer be considered an eligible Dependent.

Physical Disability means a Dependent child's substantial physical or mental impairment which:

(1) results from injury, accident, congenital defect, or sickness; and
(2) is diagnosed by a Physician as a permanent or long term dysfunction or malformation of the body.

A non-covered child who is ineligible due to age may be eligible for coverage under this Physical Disability provision if the child meets the requirements above.

Spouse means a person who is legally married to the Employee.

B. When You are Eligible for Coverage

If you are an Employee, as defined, you are eligible for coverage the day This Plan goes into effect at your Employer's location. If your employment commences after such date, you are eligible for coverage on the date selected by your Employer following the commencement of your employment.

C. When Your Dependents are Eligible for Coverage

Your Dependents are eligible for coverage the same day as you, provided that you have eligible Dependents on that date. If you later acquire a Dependent, that Dependent is eligible for coverage on the date acquired.

D. Newborns

Your newborn child will be automatically covered until the child attains 31 days of age. If you do not enroll this child for Dependent coverage before the end of the 31 days, no further benefits will be available. Enrollment will be delayed until the next open enrollment period, as defined by your Employer, unless a Special Enrollment Provision is met.

E. How You Enroll for Coverage

To enroll for coverage, obtain an enrollment form from your Employer. Complete the form providing all requested information applicable to you and your Dependents. Sign the form and return to your Employer on a timely basis.

F. When You Become Enrolled for Coverage

1) *Noncontributory Coverage*

If no contributions are required from you for the coverage, you are covered the first day you are eligible.

If no contributions are required from you for Dependent coverage, your Dependents will be covered on the first day you are eligible for Dependent coverage.

2) *Contributory Coverage*

If contributions are required from you for the coverage, coverage begins on the first day you become eligible. If you delay your enrollment more than 31 days beyond the date you were first eligible, then your enrollment is delayed until the next open enrollment period as defined by your Employer, unless you meet Special Enrollment Provisions.

If contributions are required from you for Dependent coverage, your Dependent will be covered on the first day you become eligible. If you delay Dependent enrollment more than 31 days beyond the date the Dependent was first eligible, then your Dependent enrollment is delayed until the next open enrollment period as defined by your Employer, unless your Dependent meets Special Enrollment Provisions.

3) *Special Enrollment Provisions*

If you or your Dependent request enrollment after the first period in which you or your Dependent was eligible to enroll, you or your Dependent must meet the Special Enrollment Provisions.

The Special Enrollment Provisions are:

a) Loss of Other Coverage

A Special Enrollment Provision will apply to you or your Dependent if all of the following conditions are met:

(1) You or your Dependent were covered under another Group Health Plan or had other Health Insurance Coverage at the time of initial eligibility, and declined enrollment solely due to the other coverage.

(2) **Health Insurance Coverage** means benefits consisting of medical care, prescription drugs, dental care, or vision care, provided directly, through insurance or reimbursement, or otherwise, under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health Insurance Coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

(3) The other coverage terminated due to loss of eligibility (including loss due to legal separation, divorce, death, cessation of Dependent status, termination of employment or reduction in work hours, incurring a claim that meets or exceeds the other coverage Lifetime Benefit Maximum on all benefits, when the individual no longer resides, lives, or works in a service area and there is no other benefit package available under the other Group Health Plan, or when the other Group Health Plan no longer offers any benefits to a class of similarly situated individuals), or due to termination of Employer contributions (or, if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation).

(4) Request for enrollment is made within 31 days after the other coverage terminates or after a claim is denied due to reaching the Lifetime Benefit Maximum of all benefits under the other health coverage.

The effective date of coverage will be the date as determined by your Employer.

Loss of eligibility does not include a loss due to failure of the individual to pay contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage).

b) Newly Acquired Dependents

A Special Enrollment Provision will apply to you or your Dependent if all of the following conditions are met:

(1) You are enrolled (or are eligible to be enrolled but have failed to enroll during a previous enrollment period);

(2) A person becomes your Dependent through marriage, birth, adoption or placement for adoption; and

(3) Request for enrollment is made within 31 days after the date of the marriage, birth, adoption, or placement for adoption.

The effective date of you or your Dependent's coverage will be as follows:

(1) In the event of marriage, the date of marriage or first of following month;
(2) In the event of a Dependent child's birth, the date of such birth;
(3) In the event of a Dependent child's adoption or placement for adoption, the date of such adoption or placement for adoption, whichever is earlier.

c) Court-Ordered Coverage

A Special Enrollment Provision will apply to your Dependent child if all of the following conditions are met:

(1) You are enrolled but have failed to enroll the Dependent child during a previous enrollment period;
(2) You are required by a court or administrative order to provide health coverage for the Dependent child; and
(3) Request for enrollment is made within 31 days after the issue date of the court or administrative order.

The effective date of the Dependent child's coverage will be the date of the court order.

A copy of the procedures governing Qualified Medical Child Support Orders (QMCSO) can be obtained from the plan administrator without charge.

d) Loss of Medicaid or CHIP Coverage

A Special Enrollment Provision may apply to you or your Dependent if all of the following conditions are met:

(1) You or your Dependent are covered under Medicaid or a Children's Health Insurance Program ("CHIP") and Medicaid or CHIP coverage is terminated as the result of loss of eligibility; and
(2) You request special enrollment on an appropriately completed enrollment application within 60 days after the loss of such coverage.

e) Eligibility for Employment Assistance Under Medicaid or CHIP

A Special Enrollment Provision may apply to you or your Dependent if all of the following conditions are met:

(1) You or your Dependent become eligible for a Medicaid or CHIP premium assistance subsidy; and
(2) You request special enrollment within 60 days after you or your Dependent is determined to be eligible for assistance.

G. Change in Family Status

Once you are enrolled in This Plan, You must promptly enroll your eligible Dependents. You must also notify your Employer when you no longer have any eligible Dependents.

You must report the names, social security numbers and dates of birth of all eligible Dependents to your Employer.

H. When Your Coverage Terminates

Coverage for you and your Dependents terminates when:

(1) your employment terminates; or
(2) you no longer qualify as an Employee; or
(3) coverage terminates for the class of Employees to which you belong; or
(4) you discontinue required contributions; or
(5) you cease to be actively employed; or
(6) your Employer no longer participates in the Trust; or
(7) This Plan terminates.

Coverage for a Dependent terminates when:

(1) your Dependent is no longer eligible for coverage; or

(2) your Dependent's coverage under This Plan terminates; or
(3) your coverage as an Employee terminates; or
(4) This Plan terminates.

I. Continuation Privilege

Any continuation privileges below are subject to terms and conditions established by your Employer and the Plan Administrator.

1) *Employee and Dependent Continuation Privilege*

If you or your Dependent(s) lose coverage due to:

(1) termination of employment; or
(2) leave of absence; or
(3) ineligibility as an Employee; or
(4) ineligibility as a Dependent; or
(5) retirement; or
(6) death of an Employee or Retiree; or
(7) disability; or
(8) divorce;

you may be eligible to continue your dental coverage for a limited period of time by paying the required contribution as long as you or your dependents are not enrolled in another qualifying Group Health Plan.

You should contact your Employer to verify if continuation is available and to obtain the necessary forms.

2) *Retiree Continuation Privilege*

Your Employer may offer a Retiree Continuation Privilege. Please contact your Employer to verify if continuation is available.

If your Employer allows continuation for retirees, you and your eligible Covered Dependents may be eligible to continue your Dental coverage by paying the required contribution. You would be eligible if you retire at age 55 or older with at least five consecutive years of Dental coverage under This Plan prior to retirement.

Contact your Employer immediately upon retirement to obtain the necessary forms for continuation.

If you die while under the Retiree Continuation Privilege, your eligible Covered Dependents may be eligible to continue their coverage for a limited period of time by paying the required contribution.

3) *Federal Family and Medical Leave Act (FMLA) Continuation*

Federal law requires that Employees eligible for benefits under the Federal Family and Medical Leave Act (FMLA) be provided a continuation period in accordance with the provisions of the FMLA.

See your Employer to determine whether you qualify for benefits under FMLA and, if so, the terms of any continuation period.

If FMLA applies to your coverage, these FMLA continuation provisions:

(1) are in addition to any other continuation provision of This Plan, if any; and
(2) will run concurrently with any other continuation provisions of This Plan for illness, injury, layoff, or approved leave of absence, if any.

If you qualify for both state and FMLA continuation, the continuation period will be counted concurrently toward satisfaction under both.

J. Rescission

Coverage may be cancelled or discontinued retroactively if an individual (or an individual seeking coverage on behalf of an individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage is not a rescission to the extent it is attributable to a failure to pay required contributions on a timely basis toward the cost of coverage.

3. SUMMARY OF DENTAL BENEFITS

Dental Benefits are designed to help pay expenses which otherwise you would have to pay in full for Medically Necessary Dental Treatment.

Covered Charges means charges for a Treatment that is Medically Necessary.

Treatment means confinement, treatment, service, substance, material, or device.

Dentist means a Doctor of Dental Surgery or a Doctor of Dental Medicine, or a Doctor of Medicine licensed to provide dental services.

Dental Hygienist means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

Medically Necessary Dental Treatment means a Treatment that meets all of the following criteria:

(1) prescribed by a Dentist and required for the screening, diagnosis or Treatment of a dental condition;
(2) consistent with the diagnosis or symptoms;
(3) not excessive in scope, duration, intensity or quantity;
(4) the most appropriate level of services or supplies that can safely be provided;
(5) determined by Us to be Generally Accepted;
(6) is not cosmetic, and
(7) is not an Experimental or Investigational Measure.

Generally Accepted means Treatment for the particular sickness or injury which is the subject of the claim that meets all of the following criteria:

(1) has been accepted as the standard of practice according to the prevailing opinion among experts as shown by articles published in authoritative, peer-reviewed medical and scientific literature;
(2) is in general use in the relevant medical community; and
(3) is not under scientific testing or research.

Experimental or Investigational Measure means any Treatment, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field, as determined by Us.

Prevailing Charges means Covered Charges which are identified by the Plan Administrator, taking into consideration the charge which the provider most frequently bills to the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the usual range of charges billed in the same area by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. **Area** means, as appropriate, a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such Treatment, service, or supply for which a specific charge is made. To be Prevailing Charges, the charge must be in compliance with the Plan Administrator's policies and procedures relating to billing practices for unbundling or multiple procedures.

A. Dental Preferred Provider Organization (PPO)

The Plan contracts with Preferred Provider Organizations (PPO). Each time you need care, you decide whether or not to use a PPO provider. Using a PPO provider saves you and This Plan money, because these contracted providers charge This Plan a discounted rate for services. This means charges from a PPO provider are discounted, so you and This Plan share the benefit of lower negotiated costs, and you and This Plan pay less for dental care.

A listing of participating dentists and other providers is available to you via your network's website. Please refer to the Summary of Plan Benefits for PPO Network contact information and PPO and non-PPO levels of benefits.

Please note that your Employer's PPO selection does not mean that your choice of provider is restricted. You may still seek needed dental care from any dentist or other provider. However, services from providers who are not PPO providers often result in you paying more for the services that you receive and This Plan providing you with a reduced level of benefits. Therefore, you are urged to obtain care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of This Plan if We or the PPO terminate the arrangement. In the event of termination, We will pay the level of benefits for dental care received from non-PPO providers as described in the Summary of Plan Benefits.

B. Maximum Dental Payment Limits

The maximum benefit payable for Dental Covered Charges under Basic and Major Covered Charges incurred by a Covered Person during the Plan Year is as stated in the Summary of Plan Benefits. Benefits payable for Dental Covered Charges under Diagnostic and Preventive do not apply to the maximum benefit limit.

The lifetime maximum benefit payable for all Dental Covered Charges under Orthodontic Covered Charges incurred by a Covered Person eligible to receive Orthodontic Coverage is as stated in the Summary of Plan Benefits

C. Dental Benefits Payable

Dental Benefits are payable for Covered Charges incurred in the Plan Year after satisfaction of the Deductible Requirement, if applicable. Reimbursement of Covered Charges shall be payable at the percentages stated in the Summary of Plan Benefits. Covered Charges will be payable up to the Maximum Allowances stated in the Summary of Plan Benefits.

D. Deductible Requirements

There is no Deductible under Diagnostic and Preventive Covered Charges.

All Dental Covered Charges under Basic and Major Covered Charges are subject to a combined Deductible as stated in the Summary of Plan Benefits per Covered Person per Plan Year. The maximum family deductible will be limited to a combined family total of three times the individual deductible.

All Dental Covered Charges under Orthodontic Covered Charges are subject to a separate Deductible as stated in the Summary of Plan Benefits per Covered Person per Plan Year.

E. Dental Payment Qualification

To qualify for payment of the benefits provided by This Plan a Covered Person must file a Dental Treatment Plan with Us before treatment begins when charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed $300.

Dental Treatment Plan means the Dentist's report of proposed treatment which lists the procedures required for the Period of Dental Treatment, shows the charges for each procedure; and is accompanied by any diagnostic materials that We might require.

Period of Dental Treatment means all sessions of dental care that result from the same initial diagnosis and any related complications.

F. Dental Benefits Payable

Benefits payable will be as described in this section, subject to:

(1) all listed limitations; and
(2) the terms and conditions of:
   a) Coordination with Other Benefits; and
   b) Coordination with Excess Only or Secondary Only Plans; and
   c) Subrogation.

G. Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the Plan's coverage will be limited to the cost of the least expensive service or supply that is customarily used in that Area for treatment, and deemed by the dental profession to be appropriate for treatment of the condition in question.

The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition. You should review the differences in the cost of alternate treatment with your Dentist. Of course, you and your Dentist can still choose the more costly treatment method. You are responsible for any charges in excess of what This Plan will cover and/or in excess of Prevailing Charges.

H. Treatment Beginning and Completion Dates

Covered Charges for a Covered Person will include only those charges for Treatment that begins according to the **Beginning Date for Treatment**. Covered Charges for a Covered Person will include only those charges for Treatment that is completed by the **Completion Date for Treatment** except when the Treatment is covered under the **Extension of Dental Benefits After Termination** provision.

Beginning Date for Treatment means Treatment will be considered to begin:

a) for root canal therapy, on the date the pulp chamber is opened and the pulp canal explored to the apex; and
b) for crowns, fixed bridgework, inlays, or onlay restoration, on the date the tooth or teeth are fully prepared; and
c) for full or partial dentures, on the date the master impression is made;
d) for orthodontia, on the date the appliance or bands are first set; and
e) for all other, on the date the Treatment is performed.

Completion Date for Treatment means Treatment will be considered to be completed:

a) for crowns, on the date the crown is seated; and
b) for fixed bridgework, on the date the bridge is seated; and
c) for inlay or onlay restorations, on the date the inlay or onlay is seated; and
d) for complete or partial dentures, on the date the complete or partial denture is seated.

Extension of Dental Benefits after Termination means if dental coverage under This Plan ceases and a Covered Person qualifies, This Plan will pay for:

a) root canal therapy, but only if the pulp chamber was opened and the pulp canal explored to the apex while a Covered Person under this plan; and
b) crowns, bridges, inlays, or onlay restorations, but only if the tooth or teeth were fully prepared while a Covered Person under this plan; and
c) complete or partial dentures, but only if the master impression was made while a Covered Person under this plan; and
d) orthodontia, but only if the appliance or bands were first set while the Dependent child was covered under This Plan. The amount payable will be the part of the quarterly payment that would have been payable had coverage remained in force during the period extended benefits are payable;

provided the Treatment is received within 60 days after a Covered Person's coverage terminates.

A Covered Person will qualify if:

a) you or a Dependent would have qualified for benefit payment under This Plan had coverage remained in force; and
b) the Treatment began while a Covered Person under this plan; and
c) This Plan is in force at the time Treatment is received.

However, no extended benefits will be paid for Treatment received on or after the date a Covered Person becomes eligible for other group dental expense coverage.

4. SCHEDULE OF DENTAL PROCEDURES

A. Diagnostic and Preventive Care

1) Visits

(1) Office visit during regular office hours, for oral examination
(2) Routine comprehensive or recall examination (limited to 2 visits each year)
(3) Emergency examination (covered as a separate procedure only if no other service, except x-rays is provided during the visit)
(4) Problem-focused examination (limited to 2 visits each year).
(5) Histopathologic examination
(6) Pulp vitality test

(7) Palliative treatment (covered as a separate procedure only if no other service, except x-rays, is provided during the visit)

2) Cleaning & Preventive

(1) Prophylaxis (cleaning) (limited to 1 treatment in any six consecutive months)
(2) Topical application of fluoride (applicable only to children under age 16, limited to one application in any six consecutive months)
(3) Sealants (applicable only to children under age 16, limited to one application in any 24 consecutive months applicable only to first and second permanent molars)
(4) Space Maintainers (applicable only to children under age 16, fixed or removable, unilateral or bilateral, covered only when needed to preserve space resulting from premature loss of primary teeth and includes all adjustments within 6 months thereafter)

3) X-Rays

(1) Bitewing X-rays Adult (limited to 1 set in any 12 consecutive months)
(2) Bitewing X-rays Child (limited to 1 set in any 6 consecutive months for children under age 18)
(3) Complete X-ray series, including bitewings, if necessary, or panoramic film (limited to 1 set in any 36 consecutive months)
(4) Vertical bitewing X-rays (limited to 1 set any 36 consecutive months)
(5) Occlusal X-rays
(6) Periapical X-rays
(7) Extraoral X-Rays such as Sialography, TMJ, Cephalometric film, Posterior-anterior or lateral skull and facial bone survey (only one of the listed extraoral procedures will be covered in any six consecutive months)
(8) Diagnostic x-rays performed in conjunction with root canal therapy or Orthodontic Treatment will not be considered under Diagnostic and Preventive Care charges.

B. Basic Procedures

1) Restorations

Multiple restorations on one surface will be paid as a single filling. Replacement of existing fillings are covered only if at least 24 consecutive months have passed since placement of prior filling, unless required by new decay in an additional tooth surface. Mesial-lingual, distal-lingual, mesial-buccal and distal-buccal restorations on anterior teeth will be considered single surface restorations.

(1) Fillings (amalgam, silicate, plastic, or composite, including pin retention when necessary)
(2) Stainless steel crown

2) Oral Surgery

(1) Extraction of teeth
(2) Alveoloplasty
(3) Removal of dental cysts and tumors
(4) Surgical incision and drainage of dental abscess
(5) Tooth reimplantation
(6) Surgical exposure to aid eruption
(7) Surgical repositioning of teeth
(8) Excision of hyperplastic tissue
(9) Sialolithotomy: removal of salivary calculus
(10) Closure of salivary fistula
(11) Removal of exostosis
(12) Closure of oral fistula of maxillary sinus
(13) Sequestrectomy
(14) Removal of foreign body from soft tissue
(15) Frenectomy

3) Periodontic Services

(1) Scaling and root planing (each quadrant, covered once each quadrant in any 24 consecutive months)

(2) Full Mouth Debridement (covered once in any 24 consecutive months)
(3) Periodontal appliance for bruxism (one appliance is covered in any 36 consecutive months)
(4) Periodontal prophylaxis (including probing, charting, exam, polishing, scaling, root planing and similar maintenance procedures, covered only if at least three months have elapsed after completion of active therapeutic scaling and root planing or active surgical periodontal treatment and then not more than once in three consecutive months)
(5) Localized delivery of antimicrobial agents (only when in conjunction with scaling and root planing)

4) *Periodontal Surgical Procedures*

Only one of the listed periodontic surgical procedures is covered for each quadrant in any 24 consecutive months.

(1) Gingival flap procedure
(2) Gingivectomy
(3) Gingival curettage
(4) Osseous surgery
(5) Pedicle soft tissue graft
(6) Free soft tissue graft
(7) Osseous graft

5) *Endodontic Services*

(1) Vital Pulpotomy (for deciduous teeth only)
(2) Root canal therapy including Dental Treatment Plan, diagnostic x-rays, clinical procedures and follow-up care
(3) Apexification / Recalcification
(4) Apicoectomy
(5) Retrograde filling
(6) Root resection
(7) Hemisection

6) *Anesthesia*

General anesthesia or IV Sedation is covered as a separate procedure only when required for complex oral surgical procedures covered under this plan.

7) *Other Services*

(1) Repairs to bridges and complete or partial dentures
(2) Adding tooth to partial denture
(3) Relining or rebasing complete or partial denture (upper or lower, covered only if relining or rebasing is done more than 12 months after the initial insertion and then not more than once in any 24 consecutive months)
(4) Tissue Conditioning (covered only if at least 12 months have elapsed since the insertion of a complete or partial denture and not more than once in any 24 consecutive months)
(5) Denture Adjustment (covered once in any 12 consecutive months and only if at least 12 months have elapsed since the insertion of the denture)
(6) Recementing of Inlay, Onlay, Crown, Bridge, or Space maintainer
(7) Consultation with specialist
(8) Antibiotic drug injection
(9) Biopsy of oral tissue

C. Major Procedures

1) *Restorations*

(1) Inlays and onlays (covered only if the tooth cannot be restored by a filling and for replacements if at least 60 consecutive months have elapsed since the last placement)
(2) Labial Veneers (covered only if tooth cannot be restored by a filling and for replacements if at least 60 consecutive months have elapsed since the last placement)

(3) Crowns (covered only if the tooth cannot be restored by a filling and for replacements (crown, veneer, inlay, or onlay) if at least 60 consecutive months have elapsed since the last placement)
(4) Cast post and core (covered only for teeth that have had root canal therapy)
(5) Steel post and composite or amalgam (covered only for teeth that have had root canal therapy)
(6) Pins / Pin retention—per tooth, in addition to amalgam or resin restoration
(7) Core buildup, including any pins

2) *Prosthodontics, Fixed*

Initial placement of fixed prosthodontics to replace teeth which were missing prior to the Covered Person's effective date will not be covered unless it includes the replacement of a Functioning Natural Tooth extracted while the person is covered under This Plan provided that tooth was not an abutment to an existing partial denture that is fewer than five years old, in which case benefits are payable only for the replacement of those teeth which were extracted while covered under This Plan. Replacement of an existing fixed prosthodontic is covered only if the existing prosthodontic was placed more than 60 consecutive months prior, and is not serviceable, and cannot be repaired.

Natural Tooth means any tooth or part of a tooth that is organic and formed by the natural development of the body (i.e., not manufactured).

Functioning Natural Tooth means a Natural Tooth which is performing its normal role in the chewing process in the covered person's upper or lower arch and which is opposed in the person's other arch by another Natural Tooth or prosthetic (i.e., artificial) replacement.

(1) Fixed Bridges
(2) Implants / Bone Grafts (only in conjunction with implants)

3) *Prosthodontics, Removable*

(1) Complete or partial dentures (initial placement of complete or partial dentures to replace teeth which were missing prior to the Covered Person's effective date will not be covered unless including the replacement of a Functioning Natural Tooth extracted while covered under This Plan and replacement of an existing complete or partial denture is covered only if the existing denture is was placed more than 60 consecutive months prior, and is not serviceable and cannot be repaired)

4) *Temporomandibular Joint Disorders (TMJ)*

Treatment for TMJ disorder only when approved by Us. Oral appliances are covered when used to specifically treat TMJ.

D. Orthodontic Treatment

Orthodontic Treatment means any Treatment for: straightening of teeth with formal, full-banded retention and treatment, including x-rays and other diagnostic procedures; and removable or fixed appliances for tooth or bony structure guidance or retention. Orthodontic Treatment applies only to covered dependent children under the age of 19 unless otherwise stated in the Summary of Plan Benefits.

E. Additional Dental Expenses

Additional dental expenses, not covered under Another Plan, may be considered covered expenses for a Covered Person if the Covered Person has specific medical conditions approved by Us.

F. Limitations of Dental Benefits

Dental benefits will not be paid for any of the following:

(1) Treatment that is not for Medically Necessary Dental Treatment;
(2) any part of a charge for Treatment that exceeds Prevailing Charges;

(3) the services provided by any person who is not a Dentist or Dental Hygienist;

(4) any charge related to Treatment at a Hospital;

Hospital means an institution that is licensed as a hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, Custodial Care facility, or training center. Hospital shall also include an Inpatient Alcohol or Drug Abuse Treatment Facility and a Birthing Center.

(5) the services provided by any person in your Immediate Family or any person in your Dependent's Immediate Family;

Immediate Family means a Covered Person's spouse, natural or adoptive parent, child or sibling, aunt, uncle, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of grandparent or grandchild.

(6) personalization of dentures or crowns and any other Treatment that is primarily cosmetic;

(7) Treatment that does not meet professionally recognized standards of quality or that is an Experimental or Investigational Measure;

(8) drugs and medicines (except for antibiotic injections);

(9) bite registration or occlusal analysis;

(10) instruction for plaque control, oral hygiene, or diet;

(11) Treatment to alter or maintain vertical dimension or restore or maintain occlusion;

(12) Treatment for provisional or permanent splinting;

(13) Treatment for the purpose of duplicating or replacing a lost or stolen prosthetic device or appliance;

(14) crowns for the primary purpose of periodontal splinting, altering or maintaining vertical dimension, or restoring occlusion;

(15) crowning of implant replacing a tooth missing prior to the effective date;

(16) for a Covered Person under 16 years of age, the benefit for crowns on vital teeth is limited to resin or stainless steel crowns;

(17) Treatment that is temporary;

(18) Nitrous oxide;

(19) oral cancer screening;

(20) stress breakers;

(21) Treatment due to orthodontics (except as described under Covered Charges);

(22) Treatment covered under the Comprehensive Medical Benefits Plan;

(23) Treatment provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:

(b) travel, provided the travel is for a reason other than securing medical or dental care diagnosis or treatment;

(c) a business assignment by a covered Employer;

(d) the Employee is employed by a covered Employer and working outside the United States; or

(e) Full-Time Student status, provided the dependent is either: enrolled and attending an accredited school in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student is enrolled in the U.S. grants academic credit;

(24) charges for which the Covered Person is not legally obligated to pay or which are for medical or dental care furnished without charge, paid for or reimbursable by or through the government of a nation, state, province, county, municipality, or other political subdivision, or any instrumentality or agency of such a government;

(25) Treatment rendered in a hospital owned or operated by the United States Government, either by the hospital or a Dentist employed by it (a) unless the treatment is of an emergency nature, and (b) unless the Covered Person is not entitled to such treatment by reason of his status as a veteran or otherwise;

(26) Treatment for an injury or sickness which results from war, act of war, or voluntary participation in criminal activities while a Covered Person;

(27) Treatment for an injury or sickness which arise out of or in the course of employment, and which either entitles the Covered Person to benefits under a Worker's Compensation Act or similar legislation, or would have entitled the Covered Person to benefits if coverage under such a statute could have been in force on a voluntary or elective basis;

(28) Treatment provided by any person, hospital, or entity whose charges for medical or dental care, depend on the patients' financial ability to pay or availability of coverage;

(29) charges which are eligible to be paid by a previous group plan which was replaced by enrollment in the Christian Brothers Employee Benefit Trust;

(30) charges for disease or injury covered by a workers' compensation act or similar legislation, or that would have been covered if elected; or

(31) Treatment incurred after termination of coverage under This Plan, except as provided by This Plan.

5. DENTAL CLAIM & APPEALS PROCEDURES

A. Dental Claim Procedures

1) *Claim Forms*

Special claim forms are not required to file a claim with Us. Standard industry computerized forms may be used by your providers to submit a claim. When you become covered, you will be issued an identification card. This card should be presented to each provider at the time a Covered Person receives needed dental Treatment.

All Claims Must Be Received By Us Within One Year From The Date of Service To Be Eligible For Benefit Consideration.

Proof of loss sent later will be accepted only if there is reasonable cause for the delay and if the claim is received no later than two years after date of service.

For purposes of satisfying the claim processing requirements, receipt of claim will be considered to be met when We receive proof of claim. Proof of claim includes the patient's name, your name (if different from the patient's name) and identification number, patient's date of birth, provider of services, dates of services, diagnosis, description of Treatment provided, and the amount of claim. We may request additional information to substantiate your loss or require a signed unaltered authorization to obtain information from the provider. Your failure to comply with such request could result in your claim being declined.

2) *Payment and Denial*

We will process your claim as quickly as possible after We have received all the required information, but not later than 30 days after receipt of the claim and all supporting documentation.

If We cannot render a decision within 30 days because you have not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under This Plan, the denial notice will describe the specific information needed to complete the claim. You will have 45 days from receipt of the notice to provide the required information. We will then have 30 days from the date of receiving your information to render Our decision.

3) *Dental Examinations*

We may have the person whose loss is the basis for dental claim examined by a Dentist. We will pay for these examinations and will choose the Dentist to perform them.

4) *Release of Medical Information*

As a condition of receiving benefits under This Plan, you and your Dependents authorize:

(1) any provider to disclose to Us any medical or dental information We request;
(2) Us to examine your medical or dental records at the office of any provider;
(3) Us to release to or obtain from any person or organization any information necessary to administer your benefits; and
(4) Us to examine your employment records in order to verify your eligibility.

5) *Form and Content of Notice of Adverse Benefit Determinations*

If an adverse benefit determination is made, including a denial of a claim in whole or in part, or a rescission of coverage, notice of such adverse determination will be provided to you. Notice will be written in either paper or electronic format; oral notice might be provided only with respect to urgent care claims, but only if written confirmation is furnished to you within 3 days after the oral notice is provided.

The notice will include the following:

(1) the specific reason or reasons for the adverse determination, including the denial code, the meaning of the code and the standard, if any, used in denying the claim;
(2) reference to the specific Plan provisions on which the determination is based;
(3) if applicable, a description of any additional information needed for you to perfect the claim and an explanation of why such information is needed;
(4) a description of the Plan's review procedures, including a statement of your right to a Plan committee appeal;
(5) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
(6) if the adverse determination is based on Medical Necessity, Experimental or Investigational Measure or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of This Plan to your medical or dental circumstances, or a statement that this will be provided without charge upon request;
(7) information sufficient to identify the claim involved, including the date of service, the provider, the claim amount, the diagnosis code, the Treatment code and the corresponding meanings of these codes; and
(8) information about the availability of, and contact information for, any applicable office of health insurance consumer assistance who can assist you with internal claim appeals processes.

B. Right of Recovery

If it is determined that benefits paid under This Plan should have been paid by any other plan, We will have the right to recover those payments from:

(1) the person to or for whom the benefits were paid; and/or
(2) the other companies or organizations liable for the benefit payments.

To the extent permitted by law, the rights of any Covered Person under This Plan may not be voluntarily or involuntarily transferred or assigned; provided, however, that all benefits of a Covered Person shall be paid to the permitted providers of care except to the extent that the Covered Person submits a provider statement showing that the Covered Person has paid the provider all or a portion of the covered expenses for which benefits are payable under This Plan.

1) *Assignment of Benefits*

This Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, This Plan will not recognize any assignment of a Covered Person's right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to the Covered Person (with or without an assignment), it is solely the responsibility of the Covered Person to reimburse the provider.

2) *Applicability*

Where allowed by law, this section will apply to Covered Persons who:

(1) receive benefit payment under This Plan as the result of a sickness or injury; and
(2) have a lawful claim against another party or parties for compensation, damages, or other payment because of that same sickness or injury; and
(3) recover payment from such party or parties which includes an amount (or part of an amount) previously paid under This Plan for Treatment.

3) *Transfer of Rights*

In those instances where this section applies, the rights of the Covered Person to claim or receive compensation, damages, or other payment from the other party or parties will be transferred to the Trust, but only to the extent of benefit payments made under This Plan.

C. Dental Appeal Procedures

1) *Internal Appeal*

You or your authorized representative may request an appeal of an adverse benefit determination, a claim denied in whole or in part, within 180 days of receipt of notice of the adverse benefit determination. Any such written request for review must state the reason or reasons why you believe that the original decision was incorrect.

If more information is needed, We will send a written request for the additional information. You, the patient, the Dentist, or the facility rendering the service is permitted up to 45 days to provide the necessary information. Failure to receive the additional information could result in your appeal being denied. A determination will be made and notification of the outcome will be provided within 30 days of the receipt of all necessary information to properly review the appeal request. Any urgent care appeals received will be decided within 72 hours of receipt and you will be provided written notification of the appeal determination.

During the appeal:

(1) you will be given reasonable access to, and copies of, all documents relevant to the claim, free of charge;
(2) you will be permitted to review the claim file and present evidence and testimony;
(3) if any new or additional evidence is considered, relied upon, or generated by This Plan or if Our decision is based on a new rationale, then We will provide you with such evidence or rationale sufficiently in advance of the date by which We are required to decide the final appeal in order to provide you with reasonable opportunity to respond prior to such date;
(4) you may submit documents, issues and comments in writing and such material will be considered on review without regard to whether it was considered in the original benefit determination;
(5) if the denial was based on a medical or dental judgment, you have the right to have your claim reviewed by a health care professional with appropriate training and experience in an applicable field who was not consulted during the initial benefit determination;
(6) you shall have the right to have identified to you the experts whose advice was obtained in connection with the initial adverse benefit determination, even if the advice was not relied on;

(7) if We fail to strictly adhere to all the requirements of the internal claim and appeal procedures set forth above, you will be deemed to have exhausted the internal claim and appeal procedures and may initiate a Plan Committee appeal.

(8) The review of a claim denial during the internal appeal will be conducted by a Plan fiduciary who will not be the individual who made the initial adverse benefit determination, nor the subordinate of such individual. This fiduciary will not give deference to the initial claim denial or initial appeal decision.

If your claim is denied during the appeal process, in whole or in part, the written notice will include:

(1) the specific reason or reasons for the adverse determination, including the denial code, the meaning of this code, the standard, if any, used in denying the claim and a discussion of the decision;

(2) reference to the specific Plan provisions on which the determination is based;

(3) a statement that you are entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to This Plan concerning the denied Treatment without regard to whether the statement was relied on;

(4) a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

(5) if the adverse determination is based on Medical Necessity, Experimental or Investigational Measure or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of This Plan to your medical or dental circumstances, or a statement that this will be provided without charge upon request; and

(6) information sufficient to identify the claim involved, including the date of service, the provider, the claim amount, the diagnosis code, the Treatment code, and the corresponding meanings of these codes.

If the initial appeal was denied in whole or in part, you may appeal that decision to the Plan Committee of the Plan Trustees. Your appeal must be in writing to the Plan Administrator and must be received within 60 days after your receipt of the notice of denial. You may submit written comments, documents, records, and other information relating to the claim. The Plan Committee will make a determination within 60 calendar days unless the appeal cannot be processed due to incomplete information. If more information is needed, the Plan Committee will send a written request for the additional information. Failure to receive the additional information could result in declination of the appeal. A determination will be made and notification of the outcome will be provided within 60 calendar days of the receipt of all necessary information to properly review the appeal request.

2) *Assignment*

No Covered Person may assign to a provider his or her right to file an appeal or to file a suit for benefits. As the sole exception to this prohibition, a Covered Person may assign his right to appeal to a medical provider if the appeal involves an urgent matter.

Coordination with Other Benefits – Dental

The intent of this Coordination with Other Benefits section is to provide that the sum of benefits paid under This Plan plus benefits paid under all other Plans will not exceed the actual cost charged for a Treatment.

1) *When Coordination Applies*

If a Covered Person is covered under more than one plan, This Plan will coordinate benefits with the other plan or plans. This means that the total payment from all plans will not exceed 100% of Allowable Expenses.

This Plan means the medical, dental, and vision benefits described in this Summary Plan Document.

Another Plan means any of the following insurance or group-type insurance coverage, whether insured or self-insured, that provides benefits or services for Hospital, medical, dental, mental health and substance use disorders, prescription drug, hearing, dental or vision Treatment:

(1) Insurance coverage other than school accident type coverage;
(2) Coverage through HMOs and other prepayment, group practice and individual practice plans;
(3) The medical or dental benefits coverage in group, group-type and individual automobile no fault and traditional automobile fault type contracts; or
(4) A governmental plan, including Medicare as provided under the Social Security Act and coverage required or provided by law but not Medicaid.

The term Allowable Expenses will mean all Prevailing Charges for Treatment when at least a part of those charges are covered under at least one of the Plans then in force for the person for whom benefits are claimed.

2) *Benefits Payable under Coordination*

Claim Determination Period means the part of a Plan Year during which a Covered Person would receive benefit payments under This Plan if this section were not in force.

Benefits otherwise payable under This Plan for Allowable Expenses during a Claim Determination Period may be reduced if:

(1) benefits are payable under Another Plan for the same Allowable Expenses; and
(2) the rules listed below provide that benefits payable under Another Plan are to be determined before the benefits payable under This Plan.

The reduction will be the amount needed to provide that the sum of payments under This Plan plus benefits payable under Another Plan is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this section will be reduced proportionately; such reduced amount will be charged against any applicable benefit limit of This Plan.

3) *Order of Benefit Determination*

The benefits payable of Another Plan that does not have a coordination of benefits provision similar to the provision described in this section will be determined before the benefits payable of Another Plan that does have such a provision. In all other instances, the order of determination will be in the order set forth below:

(1) If Another Plan does not have a provision for the coordination of benefits, its benefits are payable before This Plan.
(2) If Another Plan covers a person other than as a Dependent, its benefits are payable before This Plan. This includes Medicare covering a person other than as a Dependent (e.g., a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
(3) If Another Plan covers an active Employee, its benefits are payable before This Plan. This order of determination does not supersede No. 2 above.
(4) If an individual is covered as a Dependent under two separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the birthday

rule does not apply. The following order of determination will apply:

(a) If the parent with custody has not remarried:

- The plan of the parent with custody is primary.
- The plan of the parent without custody is secondary.

(b) If the parent with custody has remarried:

- The plan of the parent with custody is primary.
- The plan of the stepparent with custody is secondary.
- The plan of the parent without custody is third.

If there is a court order that makes one parent financially responsible for the health care expenses incurred by the child, then, if a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

Benefits available for a newborn child under Another Plan for which a Covered Person are eligible, will be determined before benefits under the Automatic Coverage for a Newborn Child provision of This Plan.

If the above items do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

4) *Coordination with HMOs*

If a Covered Dependent is covered under an HMO and, pursuant to the terms set forth above, HMO must provide benefits before This Plan, the Dependent is required to access benefits available under the HMO.

If the Covered Dependent does not access benefits available under the HMO, This Plan will only consider 50% of This Plan's Covered Charges applicable to such Covered Dependent.

5) *Coordination with Excess Only or Secondary Only Plans*

If a Covered Person is covered by Another Plan containing a provision, either excess only or secondary only of other available benefits This Plan will be prorated between This Plan and Another Plan on an equal basis.

6) *Exchange of Information*

Any person who claims benefits under This Plan must, upon request, provide all information We believe is needed to coordinate benefits.

In addition, all information We believe is needed to coordinate benefits may be exchanged with other companies, organizations, or persons with whom we are coordinating benefits.

7) *Facility of Payment*

We may reimburse any other plan if:

(1) benefits were paid by that other plan; but
(2) should have been paid under This Plan in accordance with this section.

In such instances, the reimbursement amounts will be considered benefits paid under This Plan and, to the extent of those amounts, will discharge Us from liability.

8) *Reimbursement/Subrogation*

If This Plan provides any benefits in connection with a Claim by a Covered Person, the Covered Person shall reimburse This Plan, to the extent of all amounts that This Plan has paid, from any amounts that the Covered Person recovers from any source other than This Plan in connection with the Claim. The Covered Person's recovery from a source other than This Plan shall not be reduced by the amount of the Covered Person's attorney fees or for any other reason whatsoever, until This Plan has been repaid in full.

In addition, This Plan shall be subrogated to any legal rights which the Covered Person may have to recover against any party in connection with the Claim.

This reimbursement/subrogation provision applies to recoveries available to minor children from sources other than This Plan.

By accepting benefits under This Plan, the Covered Person hereby grants a lien and assigns to This Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Covered Person. The assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a claim provided said attorney, insurance carriers or others have been notified by This Plan or its agents.