DIRECT REIMBURSEMENT DENTAL PLAN
SUMMARY PLAN DESCRIPTION
FOR
SELF SKILLED NURSING HOME, LLC

CLAIMS PROCESSOR

Mike Edwards Benefit Group,
Inc. 4453 Willow Bend Dr.
Gardendale, AL. 35071

September 1, 2022

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INTRODUCTION

A. Introduction

Self Skilled Nursing Home LLC Health and Rehab LLC ("Plan Sponsor") has hereby established the Direct Reimbursement Dental Plan for the Employees of Self Skilled Nursing Home LLC Health and Rehab LLC.. ("Plan") to provide dental benefits to its eligible Employees and their eligible Dependents. The Plan is a self-funded group dental plan, which is a type of welfare benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

The Covered Person shall be responsible for sharing in the costs through contributions toward Plan coverage, Coinsurance, Copayments, and Deductibles.

The Employer is responsible for at least a portion of the cost of an Employee's dental care coverage. If an Employee elects to enroll Dependent(s) in the Plan, he or she may be responsible for a portion of that cost. The Employer shall pay costs in excess of the Employee's obligations. Contributions from the Employer and the Employees, if any, are used to provide benefits under the Plan.

The provisions of the Plan Document do not modify the terms of any insurance policy or ancillary coverage.

The Employer fully intends to maintain the Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend, in whole or in part, any or all of the provisions of the Plan (including any related documents and underlying policies) at any time, and for any reason, upon prior written notice to all Employees.

B. The Purpose of the Plan

The purpose of the Plan is to provide certain dental & limited vision benefits for eligible Employees of the participating Employer(s) and the eligible Dependents of such Employees.

C. The Purpose of the Plan Document

The Plan Sponsor is required under ERISA to provide to Employees a Plan Document or Summary Plan Description.

This Plan Document has been adopted and is being provided as the written description of the Plan and as a Summary Plan Description. This Plan Document replaces any and all statements regarding dental care coverage contained in any Plan Document or Summary Plan Description previously provided to Employees. The Plan Document is not a contract of employment between the Employer and the Employee, and does not give the Employee the right to be retained in the service of the Employer.

The Plan Document includes provisions that may result in an Employee being deemed ineligible for or being disqualified from coverage or that may result in the denial, forfeiture, loss, offset, recovery, reduction, or suspension of benefits that a Covered Person might otherwise reasonably expect the Plan to provide. Covered Persons should review this Plan Document carefully so that they understand how its provisions affect payment of benefits under the Plan.

The Plan Document will automatically be modified to comply with any federally-mandated provisions. The Plan shall notify Employees in writing of any material modification to the Plan in accordance with federal law. To the extent applicable, the Plan will provide coverage and benefits in accordance with the requirements of all applicable laws, including USERRA, COBRA, HIPAA, FMLA and PPACA. Employees are required to keep the Plan Administrator informed of any changes in address with respect to themselves and any covered Dependents. Employees are encouraged to maintain a copy of any notices sent to the Employee by the Plan Administrator or to the Plan Administrator by the Employee.

GENERAL PLAN INFORMATION

A. General Information

Name of Plan:	Direct Reimbursement Dental & Vision plans for the Employees of Self Skilled Nursing Home, LLC.
Plan Sponsor/Plan Administrator	Self Skilled Nursing Home LLC 131 East Crest Rd Hueytown, AL. 35023
Participating Employer:	Self Skilled Nursing Home LLC
Plan Sponsor ID Number (EIN):	87-0914616
Plan Number:	502
Plan Effective Date:	September 1st. 2022
Plan Revision Date:	September 1st. 2022
Plan Year:	September 1st through August 31st
Plan Benefits:	Dental and Limited Vision
Named Fiduciary:	Matthew Lewis - Administrator 131 Crest Rd. Hueytown, AL. 35023 (205) 491-2411 Office (205) 491-8750 Fax
Agent for Service of Legal Process: Note: Legal process may also be served up the Plan Administrator or a named Fiduciary	Self Skilled Nursing Home LLC . 131 Crest Rd. Hueytown, AL. 35023
Claims Processor:	Mike Edwards Benefit Group Inc. 4453 Willow Bend Dr. Gardendale, AL. 35071 Telephone: (800) 463-8020 Fax: (888) 415-6897

B. Administration Expenses

In addition to being used to pay for benefits, contributions to the Plan may be used to pay reasonable administrative and operating expenses of the Plan, including but not limited to expenses incurred in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and the Claims Processor; auditing administration agreement between the Plan Sponsor and the Claims Processor; auditing fees incurred with respect to claims submitted by or on behalf of a Covered Person; legal fees and costs associated with Plan-related issues, including those which may arise when a Claimant appeals an adverse benefit determination; and costs incident to securing or posting of any bond.

C. Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverage under the Plan shall be paid by the Plan Sponsor.

NOTE: In providing benefits and paying administrative expenses and any taxes required by law, the contributions made by Employees shall be used first. Any remaining Plan obligations shall be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess shall be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at the Plan Sponsor's discretion, may be used in any other manner consistent with applicable law.

Dental Schedule of Benefits: (See page 8 for dental limitations & exclusions)

Effective for those meeting the eligibility and waiting period requirements identified below.

Annual Maximum Benefits Paid
Annual Maximum Reimbursement for Dental Expenses per Plan Year is $1,000 per person.

Copayment Levels for Covered Expenses

Amount of Dental Expense	Plan Pays	Employee Pays	Paid Benefit
First $200	100%	0%	$200
Next $500	80%	20%	$400
Next $800	50%	50%	$400

Limited Benefit Vision Plan:

The limited benefit vision plan schedule of benefits.

The plan pays 100% of the first $100 in vision care expenses
then
50% of the next $300 in vision care expenses.

Maximum Plan year benefit is $250 per participant

To be eligible to receive the benefit, the employee and dependants must be active enrollees in the Phoenix Healthcare LLC Dental Benefits Plan.

Limitations and Exclusions of the Limited Benefit Vision Plan:

Covered expenses will not include and no benefits will be payable for expenses incurred for:

1. Vision exams more than once in any twelve (12) month period.
2. Prescribed lenses more than once in any twelve (12) month period.
3. Frames more than once in any twelve (12) month period.
4. Contact lenses more than once in any twelve (12) month period. When chosen, contact lenses shall be in lieu of any other lens benefit and frame benefit during any twelve (12) month period. When lenses are chosen, expenses for contact lenses are not covered expenses during any twelve (12) month period.
5. Examinations performed or frames or lenses ordered before the insured was covered under eye care expense benefits.
6. Examinations performed or frames or lenses ordered after the insureds coverage under the eye care expense benefits ceases.
7. Non-prescription lenses or sunglasses
8. Replacement or repair of lost or broken lenses or frames except at normal intervals.
9. Medical or surgical treatment of the eye.
10. Lenses and frames during the first twelve (12) months that a person is insured under the eye care expense benefits, when the insured is a Late Entrant as defined.

Definitions as Used Herein

Employer: The Employer is Self Skilled Nursing Home LLC.
Plan: The benefit described herein and called the Self Skilled Nursing Home, LLC, Dental Benefits Plan.

***Eligible Employee*:** A regular full-time employee of the Employer. A full-time employee is considered to be an individual who works 32 hour or more a week. Persons rendering services to the Employer as independent contractors or as employees of a leasing service or other third party are not Eligible Employees even if subsequently characterized as employees for other purposes.

Eligible Dependents: (1) Legal spouse of an Eligible Employee. (2**) Unmarried children of an Eligible Employee to age 19 provided such children are dependent upon the employee for support and maintenance. College age children shall be covered provided they are full-time students**. (3) Children of an Eligible Employee who have attained the age specified in item 2 above who are incapable of self-sustained employment due to a handicap or disability and are still dependent on the Eligible Employee. No person will be considered an Eligible Dependent unless the Eligible Employee is able to claim the person as a dependent for federal income tax purposes (unless either the person cannot be claimed as the Eligible Employee's dependent for tax purposes solely because the Eligible Employee is a dependent of another taxpayer, the person is married, or the person has insufficient gross income, or the right to claim the person as a dependent was awarded to the Eligible Employee's ex-spouse under a divorce decree).

***Waiting Period*:** The period of time an employee must be employed by the Employer prior to becoming eligible for coverage under the Plan. The waiting period is 30 days, including employment with the Employer prior to the effective date of the Plan.

Benefit Period: The 12 month period in which dental benefits are calculated. A Benefit Period shall start on September 1st and end on August 31st; each successive September 1st shall start a new Benefit Period

Carryover Benefit: There is no carryover benefit in this plan. Unused benefits in a plan year may not be carried over or used in a succeeding plan year.

***Covered Person*:** an Eligible Employee who has satisfied the waiting period and such individual's Eligible Dependents.

***Covered Expenses*:** the reasonable cost of professional services rendered to a Covered Person by a Dentist, or by a person (such as an oral hygienist) working under the supervision of a Dentist, including routine checkups and cleaning, but not including any excluded expenses listed below.

***Dentist*:** A properly licensed person who is a dentist and who is rendering services and treatment within the scope of his/her licensure and training.

***Administrator*:** The Administrator is the person or firm responsible for the day-to-day functions and management of the Plan. The name, address and phone number of the Administrator is:

Self Skilled Nursing Home LLC
131 Crest Rd
Hueytown, AL. 35023
(205) 491-2411

***Plan Service Provider*:** The Plan Service Provider is the person or firm responsible for providing claims services as directed by the Administrator. The name, address and phone number of the Plan Service Provider is:

Mike Edwards Benefit Group Inc.
4453 Willow Bend Dr.
Gardendale, AL. 35071
(800) 463-8020

Filing Dental Claims

1. Submit your paid receipt or itemized statement, along with a completed claim form to:
   Mike Edwards Benefit Group Inc.
   4453 Willow Bend Dr.
   Gardendale, AL. 35071

2. Have the licensed dentist fax or mail a completed claim form to:
   Mike Edwards Benefit Group Inc.
   4453 Willow Bend Dr.
   Gardendale, AL. 35071
   Fax: (888) 415-6897

Vision Claims Reimbursement:

The participant must submit itemized receipts from the eye care provider within 90 days of receiving services to the following administrator. Failure to submit receipts within 90 days will result in benefits not being payable.

Mike Edwards Benefit Group Inc.
4453 Willow Bend Dr
Gardendale AL 35071
Fax: (888) 415-6897

Individual Effective Date

Coverage of an Eligible Employee begins the first day of the month after the Eligible Employee satisfies the waiting period, and coverage of all persons who are then Eligible Dependents shall begin at the same time. If an Eligible Employee acquires new Eligible Dependents after becoming a covered Person (for example, by reason of marriage or birth or adoption of a child), coverage of the new Eligible Dependent will be retroactive to the date the person became an Eligible Dependent if the Eligible Employee notifies the Administrator within 30 days; otherwise coverage will not begin until the Administrator is notified.

Individual Termination of Coverage

The coverage of any Covered Person will terminate on any of the following dates, except to the extent the Covered Person is entitled to continue his/her coverage under COBRA as described below.

a. the date of termination of the Plan; or
b. the date that he/she ceases to be an “Eligible Employee” or “Eligible Dependent”; or
c. the date all or certain benefits are terminated for his/her particular class of employee by modification of the Plan.

Each Eligible Dependent’s coverage shall cease on the date the Eligible Employee’s coverage terminates.

Dental Expense Benefits

After the Employee or licensed Dentist submits a paid receipt, itemized statement or a completed dental claim form, as proof that a Covered Person has incurred Covered Expenses for care or treatment by a Dentist, the Plan will pay up to the Maximum Reimbursement specified in the Schedule of Benefits for the service(s) provided. Claims must be submitted within ninety (90) days of the date on which charges were incurred. Amount payable is subject to coordination of benefits is applicable.

Exclusions and Limitations of the Self Skilled Nursing Home, LLC. Dental Benefits Plan

1. Labial veneers and laminates done for cosmetic purposes. However, when performed for restorative purposes, labial veneers and laminates are covered under the same conditions and to the same extent that amalgam and composite restorations are covered.

2. Alteration of vertical dimension and the restoration or maintenance of occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition, and restoration for mal-alignment of the teeth.

3. Orthodontic services (treatment of poor alignment of teeth and or jaws)

4. Services with respect to any disturbance of the temporomandibular joint (jaw joint)

5. Charges for anesthesia, other than by a licensed Dentist for administering general anesthesia in connection with covered oral surgery services.

6. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility

7. Experimental procedures

8. Prescribed drugs, medications or analgesia

9. Any single procedure started prior to the date the person became covered for such services under this program.

11. Services for injuries or conditions which are compensable under workers compensation or employers liability laws; services which are provided to the enrollee by any federal or state government agency or
12. are provided without cost to the enrollee by any municipality, county or other political subdivision except as such exclusion may be prohibited by law.

11. Services with respect to congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons, including but not limited to cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorisis of the teeth and anodontia, except those services provided to newborn children for congenital defect or birth abnormalities.

12. The plan will not pay to replace any crown, jacket or cast restoration which the patient received in the previous five (5) year.

13. Crowns, jackets and cast restorations are limited to enrollees who have been enrolled in the plan for 12 consecutive months. This provision will be waived for employees and their dependent enrolling on the Effective date.

14. This plan will not pay to replace any bridge or denture that the patient received in the previous five (5) years. An exception is made if the bridge or denture cannot be made satisfactory due to a change in supporting tissues or because too many teeth have been lost.

15. This plan limits benefits for dentures to a standard partial or complete denture.

16. Prosthodontic/Denture Benefits are limited to Enrollees who have been enrolled in this plan for 12 consecutive months. This provision will be waived for employees and their dependents enrolling on the Effective Date.

17. Gold foil restorations

18. Charges for implants

19. Purchases of toothbrushes, toothpaste, floss, or other personal care items, including nonprescription drugs.

20. Procedures covered under the Employer's medical plan, whether or not the Covered Person is enrolled in the medical plan.

21. Any other expenses, which are determined by the Administrator and communicated to Eligible Employees by notice or other reasonable means.

Limitations on Diagnostic and Preventive Benefits:

a) Routine oral examinations and cleanings, including periodontal cleanings, are not provided more than twice (2) in any twelve (12) month period while the patient is an Enrollee under this plan.

b) Full mouth x-rays or panographic x-rays will be provided when required by the Dentist, but no more than once each 5 years will be paid by the Employer.

c) Bitewing x-rays are limited to twice in any 12 month period when provided to Enrollees under age 18 and once each 12 months for Enrollees age 18 and over.

d) The Employer will not pay for topical application of fluoride for anyone nineteen (19) years or older.

Coordination of Benefits

The purpose of this plan is to help you meet the cost of needed dental care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. Benefits payable by this Plan and any other group dental or medical plan may be coordinated so that the total benefits allowed will not exceed the amount which would have been allowed if no other plan were involved. All benefits provided hereunder are subject to this provision. In addition, if you are entitled to receive compensation or reimbursement from any other person with regard to any Covered Expenses that are reimbursed under this plan, the Plan will be subrogated to you, which means that the Plan is entitled to enforce your right to the compensation or reimbursement in your name.

Additional Information

Summary Plan Document

The Employer has issued this document to each Eligible Employee who is a Covered Person under this Plan. This document summarizes the benefits to which Covered Persons are entitled, to whom benefits are payable, and the provisions of this Plan principally affecting employees and their dependents.

Administration of Plan

The Plan is administered by the Administrator. The Administrator may delegate its authority to any person, including any officer or employee of the Employer, any committee or third party administrator. In the absence of any other delegation, the authority to administer the Plan shall be exercised by the senior officer of the Employer responsible for human resources or personnel, or persons acting under his/her authority. Fiscal records are maintained for the Plan Year ending the last day of August each year. The Administrator has the sole authority to interpret the Plan, to adopt rules and procedures for the administration of the Plan, and to resolve all issues regarding the Plan, including eligibility for participation and payment of benefits. All determinations made by the Administrator are final and binding on all parties.

Acceptance of Legal Notice

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon Self Skilled Nursing Home LLC.

Plan Amendment or Termination

The Plan may be amended or terminated by the Employer at any time. Any amendment or termination may be approved by either the Board of Directors or, unless the Board of Directors otherwise determines, the Chief Executive Officer of the Employer. In addition, any revision to the benefits provided under the Plan, or to the procedures for administering the Plan or applying for benefits, adopted by the Administrator and communicated to the Covered Persons shall be deemed an amendment to the Plan. In the event of Plan termination, the Employer will have no obligation under the Plan beyond paying the difference between the claims incurred (even though later filed) and expenses of the Plan due up to the date of termination. Such claims and expenses shall be paid as normal expenses of the Plan.

Plan is Not a Contract

The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee.

Appealing Denial of a Claim

If your claim is denied in whole or in part, you will receive written notification from the Administrator within 30 days of the date you filed the claim. The 30-day period may be extended by up to an additional 15 days if necessary and you will be notified of any such extension. A claim work sheet will be provided showing the calculation of the total amount payable, charges not payable, the reason, and the steps you may take to have the claim reviewed. If additional information is needed for payment of a claim, the Administrator will notify you within the initial 30-day period, and you will have 45 days to submit the additional information. If your claim is denied, you may request a review by filing a written application with the Administrator. The denial of your claim will then be reviewed by an officer or committee appointed by the Employer for this purpose who will not be the same person who originally denied your claim (or a subordinate of such person). The person reviewing the claim will conduct a full review, without deferring to the initial denial, and if the denial is based upon a medical judgment, will consult with an independent health care professional. You may submit your opinion of the issues and your comments in writing. Requests for review must be filed within 180 days after you receive notice of denial. A decision will be made promptly within 60 days and will be delivered to you in writing setting forth specific reasons for the decision and specific references to the pertinent plan provisions upon which the decision is based. The decision will be final, except as provided in the following sentence. If you still disagree with the denial of your claim following the review, you have the right to file a lawsuit under the Employee Retirement Income Security Act. However, by participating in the plan you agree not to sue unless you have filed your claim in a timely manner and appealed the initial denial of your claim within 180 days as described above. In addition, you agree not to sue more than 180 days after your appeal is denied. For more information on your right to sue for benefits (including the situation in which the losing party may be required to pay the other side's attorney fees), see "Rights of Employees (ERISA)" below.

Rights of Employees (ERISA)

As a person covered under this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all people covered by the Plan are entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Administrators office and at other specified locations, such as worksites all Plan documents including insurance contracts and a copy of the latest annual report (Form 5500 series)(if required) filed by the Plan with the U.S. Department of Labor.

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

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

Continue Plan Coverage

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

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Plan participants, ERISA imposed duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

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

Assistance with Your Questions
If you have any questions, about the Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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.

Continuation of Coverage under COBRA

The federal law requirements of the Consolidated Omnibus Reconciliation Act of 1985 (commonly known as “COBRA”), as amended from time to time, apply to the Plan if the employer falls under the guidelines for COBRA. The following is intended to inform you and your Eligible Dependent(s) in summary fashion of your rights and obligations under COBRA. You and your spouse (if any) should take time to read this summary.

If you or your Eligible Dependent(s) lose coverage under the Plan because of any of the qualifying events described below, you and your Eligible Dependent(s) may elect to temporarily continue Plan coverage according to COBRA rules. You may also elect COBRA continuation coverage for an eligible child who is born to you, adopted by you, or placed for adoption with you while your COBRA continuation coverage (or your right to elect COBRA continuation coverage) is effective, provided that you notify the Administrator within 30 days after the date of birth or adoption.

Qualifying Events

A “qualifying event” is any of the following:

- For you, and your eligible covered spouse and other Eligible Dependent(s), termination of our employment with the Employer (other than for gross misconduct) or reduction of your hours worked, so that you are no longer an Eligible Employee.
- For your eligible covered spouse and other Eligible Dependent(s):
  --Your death; or
  --Your divorce or legal separation from your spouse.
- For your eligible dependent child, the child ceasing to qualify as an Eligible Dependent under the Plan, for example because of age, marital status, or ceasing to be a full-time student.

Important Notice Requirements

You, your covered spouse, and other Eligible Dependent(s) must notify the Administrator of a divorce or legal separation or when an Eligible Dependent child ceases to qualify as an Eligible Dependent under the Plan. You must provide this notice within 60 days from whichever date is later, the date of the event or the date on which Plan coverage would be lost because of the event.

If this notice is not provided in a timely manner, the right to continuation coverage based on COBRA rules will be lost.

The Employer is required to notify the Administrator of your death, your termination of employment or the reduction in your hours worked.

The Administrator will, within 14 days of being notified of a qualifying event, advise you and your Eligible Dependent(s) of the right to elect continuation of coverage under the Plan. You or your Eligible Dependent(s) must elect continuation coverage under the Plan within 60 days or the later of the following:

- The date you or your Eligible Dependent(s) would lose Plan coverage because of the qualifying event; or
- The date you or your Eligible Dependent(s) are advised by the Administrator of the right to continue Plan coverage based on COBRA rules.

Notice to your eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any Eligible Dependent children residing with your spouse. If you or your Eligible Dependent(s) do not elect continuation of coverage within this election period, then the right to COBRA continuation coverage will be lost.

Payment of Continuation Coverage
You and your Eligible Dependent(s) will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage. You will be advised of coverage cost when you become eligible. The contributions must be paid by a check made payable to the Employer.

Contribution amounts and benefits for continuation coverage are subject to change. You will be notified of any changes in contribution amounts or benefits available under the Plan.

If you or your Eligible Dependent(s) elects to continuation coverage after the qualifying event, then you or your Eligible Dependent(s) will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of your payment. There is no grace period for the initial contribution. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

If any contribution payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Plan will terminate on the first day of the month payment was due and will not be reinstated.

Duration of Continuation Coverage
If you or your Eligible Dependents elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment or reduced work hour is 18 months.

The 18-month period may be extended to 29 months (an additional 11 months) if the Social Security Administration ("SSA") determines that you or any of your Eligible Dependent(s) were disabled at any time during the first 60 days of continuation coverage. Non disabled family members of the disabled individual who are entitled to COBRA continuation coverage are also entitled to the disability extension.

To be eligible for the disability extension, the disabled person must remain disabled and must notify the Administrator.

- Within 60 days after receiving the disability determination from the SSA, an
- Before the original 18-month period of continuation coverage ends.

A qualified beneficiary who is entitled to a disability extension may be required to pay up to 150% of the cost of his or her COBRA continuation coverage. If the increased cost is required, it will apply to each qualified beneficiary who is entitled to the disability extension. You or your Eligible Dependent(s) must inform the Administrator within 30 days of the date of any final determination by the SSA that the disabled person is no longer disabled.

If a second qualifying event occurs, within the 18 or 29 month period (as applicable), the period to continue coverage under COBRA may be extended for up to 36 months from the first qualifying event.

For all other qualifying events, the maximum period to continue Plan coverage is 36 months.

Termination of Continuation Coverage

Other events will cause your right to continue Plan coverage to end sooner. The right to continue Plan coverage will end before the maximum period on the earliest of the following:

- The date the Employer ceases to provide any dental plan coverage for employees;
- The date you or your Eligible Dependent(s) fail to make the required contribution when due;
- The date after you or your Eligible Dependent(s) first become, after your COBRA election:
  --Covered under another employer's dental plan, or
  --Entitled to Medicare.

As described above, if you or any of your Eligible Dependents are disabled, you (and you Eligible Dependents) may be eligible to extend the continuation coverage period from 18 to 29 months. However, if the Social Security Administration determines that the person who was disabled is no longer disabled, the extended period of continuation coverage will end on the first day of the first month that is at least 30 days after the Social Security Administration makes its final determination.

If you or your Eligible Dependent(s) become covered by another employer's dental plan and have a pre-existing condition that is not covered by that plan, then the right to continue Plan coverage (at least for that pre-existing condition) will not be terminated due to that other coverage.

Notice of Address Change
Please keep the Administrator informed of any address changes or changes in personal circumstances (such as a change in your marital status or if a dependent child no longer meets the eligibility requirements for a dependent child) so that we can provide you and your Eligible Dependent(s) if any, with the necessary information concerning your rights to continuation coverage.

General Information About Continuation Coverage
COBRA continuation coverage is provided subject to eligibility under the law. The Administrator reserves the right to terminate continuation coverage retroactively if you or your dependent(s) are determined to be ineligible for continuation coverage.

This Notice is only a summary under the laws of your rights and the rights of your Eligible Dependent(s) to continuation coverage. The Employer intends to provide continuation coverage only to the extent required by law and will administer continuation coverage according to those requirements. If you or your Eligible Dependent(s) have any specific questions, please contact the Administrator.

Adoption Of The Plan Document

Adoption

The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces and all prior statements of the Plan benefits described herein.

Purpose of the Plan

The purpose of the plan is to provide certain dental and limited vision benefits for eligible Employees and their Eligible Dempendents of the Participating Employer(s).
The benefits provided by the Plan are listed herein.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law or laws.

Participating Employer(s)

Employer(s) participating in this Plan are stated in the "General Plan Information". The Plan Sponsor may act for and on behalf of any and all of the Participating Employer(s) in all matters pertaining to the plan and every act, agreement or notice by the Plan Sponsor shall be l binding on all such Employer(s).

Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of September 1st, 2015.

Self Skilled Nursing Home LLC Health and Rehab LLC

By: _____

Title :_____

Date: _____