

Summary Plan Description

Delta Dental PPO

for

SCHOOL DISTRICT OF JEFFERSON

94899



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I. Plan Description Information

- 1. Plan Name:** School District of Jefferson Group Dental Plan
- 2. Plan Sponsor:** School District of Jefferson
206 S Taft Ave
Jefferson, WI 53549
- 3. Plan Administrator and Named Fiduciary:**
School District of Jefferson
206 S Taft Ave
Jefferson, WI 53549
920-675-1000
- 4. Plan Sponsor's Employer Identification Number (EIN):** 39-1207754
The Plan number assigned for government reporting purposes is 502.
- 5.** The Plan provides dental benefits for participating employees, certain retirees [if applicable], and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.
- 6.** Plan benefits described in this booklet are effective January 1, 2012.
- 7.** The Plan year and fiscal year are July 1 – June 30.
- 8. Agent for service of legal process:**
Laura J Peachey
School District of Jefferson
206 S Taft Ave
Jefferson, WI 53549
- 9.** The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Claims Administrator is:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
Telephone: 715-344-6087
Toll Free: 800-236-3712

- 10.** The Plan's contributions are shared by the employer and employee. The employer contribution is subject to change each year, depending upon claims experience and Plan expenses. The employer will pay approximately 100% of the total annual premium for employees. Retirees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.
- 11.** Each employee participating in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are this booklet. This booklet will be provided by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.
- 12.** The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to covered persons as required by applicable law.
- 13.** Upon termination of the Plan, the rights of the covered persons to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the covered persons, except that any taxes and administration expenses may be made from the Plan assets.
- 14.** The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.
- 15.** This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

II. Description of Benefits

Delta Dental has been selected by your employer to provide your dental benefits administration. All of us at Delta Dental are pleased to provide this service to you and any dependents you have enrolled. As a participant of this dental Plan, you are free to see any dentist you choose on a treatment-by-treatment basis whether or not the dentist is included in our Delta Dental PPO Dentist Directory. It is important to remember, however, that your out-of-pocket costs may be lower when you see a Delta Dental PPO dentist.

Delta Dental PPO Dentists

Delta Dental PPO Dentists have signed a contract with Delta Dental, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these dentists agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Dentists Outside the Delta Dental PPO Network

Delta Dental Premier Dentists

Delta Dental Premier Dentists have signed a contract with Delta Dental, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA); however, you are still responsible for deductibles, copayments, coinsurance, and fees for services that are not benefits under this dental Plan.

The Maximum Plan Allowance is the total dollar amount allowed for a specific benefit. The Maximum Plan Allowance will be reduced by any deductible and coinsurance you are required to pay.

Noncontracted Dentists

If your dentist has not signed a contract with Delta Dental, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the dentist. You will then reimburse your dentist through his or her usual billing procedure. You will be responsible for any amount in excess of the Maximum Plan Allowance, as well as any deductible, copayment, coinsurance, and fees for services that are not benefits under this dental Plan.

Please note that if the fee charged by a noncontracted dentist is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on each dentist's overhead, skill, and experience. Therefore, not every dentist will have fees that fall within the MPA.

For information on Delta Dental PPO or Delta Dental Premier dentists, call 800-236-3712, or visit Delta Dental's website at www.deltadentalwi.com.

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit. The MPA will be reduced by any deductible and coinsurance subscriber or covered dependent is required to pay.

Filing Claims

To file a claim with Delta Dental, simply present your ID card to the receptionist at the dental office, or give your Member ID number, which may also be your Social Security number.

Predetermination of Benefits

After an examination, your dentist may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or implants, ask your dentist to send the treatment plan with radiographs to Delta Dental. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to you and your dentist.

The Predetermination of Benefits form is valid for 1 year from the date issued.

Predeterminations are not required, but Delta Dental encourages you to use this service. Should you have any questions about a predetermination, just call us at 800-236-3712.

Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Optional Treatment

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive dental procedure that is adequate to restore the tooth or dental arch to contour and function, but only if that dental procedure is a benefit under your dental Plan. You will be responsible for the remainder of the dentist's fee if a more expensive dental procedure is selected. The coinsurance and deductible will apply regardless of which dental procedure is selected.

Summary of Benefits

Group Number: 94899

Effective Date of Program: July 1, 1999

Dependents to Age: 26 - *(Please see "Covered Dependents" in the "Eligibility" section for requirements).*

Dependents and students are covered through the end of the month the age limit is reached.

Deductibles:

Per Person, per Benefit Accumulation Period: \$0.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period: \$1,000.00

Orthodontic Maximum Benefit per Lifetime \$0.00

The benefits of your dental Plan will depend on the dentist you choose. Delta Dental PPO Dentists agree to accept payment based on a reduced schedule, which means your out-of-pocket costs will be less. The coverage percentage listed in the Delta Dental PPO column applies.

Delta Dental Premier Dentists agree to not charge you any amount that exceeds the MPA. The coverage percentage listed in the All Other Dentists column applies when treatment is provided by Delta Dental Premier Dentists or by dentists who have not signed any agreements with Delta

Benefits:	<u>Delta Dental</u> <u>PPO</u>	<u>All Other</u> <u>Dentists</u>
Diagnostic and Preventive Procedures	100%	100%
Basic Restorative Procedures	100%	100%
Major Restorative Procedures	50%	50%
Orthodontic Procedures	0%	0%

After you have satisfied the deductible requirements as stated, the program provides payment at the indicated percentage of fees, up to the maximum stated for each eligible person in each benefit accumulation period. A benefit accumulation period is a 12-month period of time over which deductibles (if any) and maximums apply. The benefit accumulation period is January 1 through December 31.

Covered Procedures

Please see the Summary of Benefits page for the coverage percent for each category.

Covered services are subject to the limitations described within each coverage category below and the Exclusions outlined later.

Diagnostic and Preventive Procedures

1. Examinations twice per calendar year.
2. Full mouth x-rays, which include bitewing x-rays, at 3-year intervals. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays twice per calendar year, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) twice per calendar year.
5. Topical fluoride applications twice per calendar year, for dependent children to age 19.
6. Space maintainers for retaining space when a primary tooth is prematurely lost.

Basic Restorative Procedures

1. Emergency treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
3.
 - a. amalgam (silver) restorations — 1 placement per tooth surface in a 1-year period;
 - b. composite (tooth-colored) restorations in anterior (front) teeth — 1 per tooth surface in a 1-year period;
 - c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.
4. Topical application of sealants for dependents to age 19.
5. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
6. Endodontics (root canal treatment and root canal fillings) — 1 per tooth in a 2-year period.
7. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical treatment once each 2 years; surgical treatment once each 3 years. Periodontal maintenance — either periodontal maintenance or adult prophylaxis at 3-month intervals.
8. Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a benefit once in any 36-month period.

Major Restorative Procedures

1. Crowns, inlays or onlays, when teeth are broken down by decay or accidental injury and may no longer be restored adequately with a filling.
2. Prosthetics (fixed bridgework, partial or complete dentures to replace missing permanent teeth);
 - a. porcelain veneers on crowns or pontics on the 6 front teeth, bicuspid and upper first molars;
 - b. replacement of a defective existing crown, inlay, onlay, fixed bridge or partial or complete denture only after 5 years from the date on which it was last supplied, regardless of who provided payment for the service;

- c. fixed bridges and partial or complete dentures where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when needed to replace missing teeth. Fixed bridges are a benefit only if the use of a removable prosthetic appliance is inadequate.

Orthodontic Procedures – listed below are not included

Orthodontic services include orthodontic appliances and treatment, and related services for orthodontic purposes, including examinations, x-rays, extractions, photographs, study models, etc., for persons eligible as stated on the Summary of Benefits page.

Your coverage includes orthodontic treatment in progress. Delta Dental's payment for orthodontic treatment in progress extends only to the unearned portion of the treatment. Delta will determine the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered by this dental plan.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental will pay only for services and supplies actually received. No benefits are available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: One-fourth of the total case fee is considered the initial or down payment fee. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percent stated on the Summary of Benefits page.

Exclusions

This dental plan does not provide coverage for the following:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer's Liability Laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this dental plan.
3. Prescription drugs, premedications or relative analgesia; charges for anesthesia other than charges by a licensed dentist for administering general anesthesia in connection with covered oral surgery (cutting procedures); preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
5. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
6. Services that are determined to be partially or wholly cosmetic in nature.
7. Cast restorations placed on eligible patients under age 12; prosthetics placed on eligible patients under age 16.
8. Appliances or restorations for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing

teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques; or for splints, unless necessary as a result of accidental injury.

9. Treatment by other than a licensed dentist, his or her employees, or his or her agents.
10. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
11. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided.
12. Replacement of lost or stolen dentures or charges for duplicate dentures.
13. Procedures or benefits not specifically provided under this dental plan or excluded by Delta Dental rules and regulations, including Delta processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

Coordination of Benefits

Applicability

This Coordination of Benefits (COB) provision applies to This Plan when you or a covered dependent has health care coverage under more than one Plan. “Plan” and “This Plan” as used in this Coordination of Benefits provision are defined below.

If this COB provision applies, the Order of Benefit Determination Rules shall be applied first. The rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

1. shall not be reduced when under the Order of Benefit Determination Rules, This Plan determines its benefits before another Plan, but
2. may be reduced when, under the Order of Benefits Determination Rules, another Plan determines its benefits first. This reduction is described in the section, Effect on the Benefits of This Plan.

Definitions

The following definitions apply to this Coordination of Benefits provision:

“Allowable Expense” means a necessary, reasonable, and customary item of dental expense that is covered at least in part by one or more of the Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the reasonable cash value of each procedure provided shall be considered both an Allowable Expense and a benefit paid.

“Claim Determination Period” means a calendar year during which Allowable Expenses are compared with total benefits payable under the policy (without applying COB). It does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

“Plan” means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid, Title XIX, grants to states for medical assistance programs, or the United States Social Security Plan whose benefits, by law, are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under 1. or 2. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

“Primary Plan/Secondary Plan”: The Order of Benefit Determination Rules state whether This Plan is a primary Plan or secondary Plan as to another Plan covering the person. When This Plan is a secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When Delta Dental is the secondary Plan, Delta Dental may reduce the benefits under its Plan only when the sum of the following exceeds the total allowable expense in a Claim Determination Period.

1. The benefits the secondary Plan would pay for allowable expenses in the absence of COB; plus
2. The benefits that would be payable under other applicable Plans for allowable expenses in the absence of COB, whether or not claim is made.

The amount by which the secondary Plan’s benefits are reduced shall be used by the secondary Plan to pay allowable expenses not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

When there are more than two Plans covering the person, This Plan may be a primary Plan as to one or more other Plans and may be a secondary Plan as to a different Plan or Plans.

“This Plan” means this dental Plan that provides benefits for dental care expenses.

Order of Benefit Determination Rules

General. When there is a basis for a claim under This Plan and other Plan, This Plan is a secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of This Plan; and
2. both those rules and This Plan’s rules described in subparagraph 2(b) require that This Plan’s benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules, which applies.

1. Nondependent/Dependent. The benefits of the Plan that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.
2. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 3c below, when This Plan and another Plan cover the same child as a dependent of different persons, called “parents”:
 - a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but
 - b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer will be determined before those of the Plan that covered the other parent.

However, if the other Plan does not have the rule described in *a.* but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - a. First, the Plan of the parent with custody of the child;
 - b. then, the Plan of the spouse of the parent with custody of the child; and
 - c. finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child’s dental care expenses or if the court decree states that both parents shall be responsible for the dental care needs of the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents’ Plan have actual knowledge of those terms, benefits for the dependent child shall be determined according to paragraph *2b*;

however, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of a child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee’s dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee’s dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule 4. is ignored.

5. Continuation Coverage.
 - a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:
 - 1) First, the benefits of a Plan covering the employee, member, or subscriber or dependent of an employee, member, or subscriber.
 - 2) Second, the benefits under the continuation coverage.
 - b. If the other Plan does not have the rule described in subparagraph a., and if as a result, the Plans do not agree on the order of benefits, this paragraph 5. is ignored.
6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If a covered person is entitled to coverage under a group health care Plan which primarily covers services or expenses other than dental care, and if the covered person first became eligible under the medical and dental Plans on the same date, this dental Plan shall be the secondary payer for those services covered by both Plans.

Effects on the Benefits of This Plan

When This Provision Applies. This “Effects on the Benefits of This Plan” provision applies when, in accordance with the “Order of Benefit Determination Rules” provision above, This Plan is a secondary Plan as to one or more other Plans. In that event, benefits of This Plan may be reduced under this paragraph so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses. Such other Plan or Plans are referred to as “the other Plans” in the “Reduction in This Plan’s Benefits” provision below.

Reduction in This Plan’s Benefits. The benefits that would be payable under This Plan in the absence of this COB provision will be reduced by the benefits payable for the total allowable expenses in a Claim Determination Period under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

No rule in other Plan. If the other Plan does not have rules coordinating benefits with those of This Plan, the benefits of the other Plan are determined first.

Right to Receive and Release Needed Information

Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without your consent, but only as needed to apply these COB rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under This Plan must give Delta Dental any facts it needs to process the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Delta Dental will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess, at its option, from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The “amount of payments made” includes the reasonable cash value of any benefits provided in the form of services.

Eligibility

Covered Employee

You are covered by this dental plan while you are an eligible employee of the group.

You may also be covered by this dental plan if you no longer meet the eligibility conditions but have elected to continue coverage as described in the **Federal Continuation Provision (COBRA)** section of this Description of Benefits.

Covered Dependents

If you are enrolled for family coverage, the following persons are covered under this dental Plan as your dependents:

1. Your lawful spouse;
2. Your children, including step and adopted children and children placed for adoption with you, who are less than 26 years of age.

3. Your children, including step and adopted children and children placed for adoption with you, who satisfy all of the following:
 - (a) The child is a full-time student, regardless of age; and
 - (b) The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and
 - (c) The child re-enrolled as a full-time student within 12 months of returning from active duty.
4. Dependent children age 26 and over who are incapable of supporting themselves because of physical or mental incapacity that began prior to their 26th birthday or the date you became eligible for this dental plan.

Dependents in military service are not covered by this dental Plan.

Dependents no longer meeting these requirements because of divorce or separation from an eligible employee, or the end of a child's dependency status may elect to continue coverage. Please see the **Federal Continuation Provision (COBRA)** section of this Description of Benefits.

Plan Sponsor reserves the right to require that an enrollee or Covered Employee seeking coverage of a dependent provide written documentation, initially and annually thereafter, that the dependent child satisfies the requirements for coverage under this plan.

Effective Dates of Coverage

You are covered by this dental Plan beginning on the first day this dental Plan becomes effective or as determined by the group.

Your eligible dependents are covered beginning on the first day you become covered under the dental Plan.

Changes in Coverage

You may change your enrollment in this dental Plan if there is a qualifying event. The enrollment change will be effective as determined by the group. Notification of the enrollment change must be received by us within 30 days of the change.

You may change your enrollment without a qualifying event during the open enrollment, if an open enrollment period is offered by your group.

Notices

Notice to the group or Delta Dental will be considered sufficient if mailed to their regular office address. Notices to you, as a subscriber, will be considered sufficient if mailed to your last known address or the last known address of the group. It is the responsibility of the group to notify you regarding changes or termination of your coverage.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the day you or your dependents are no longer eligible or the day this dental plan is terminated.

If the agreement between Delta Dental Plan and the group terminates, this document no longer describes the benefits of your dental plan.

If you or your dependents lose eligibility under the dental plan, you or your dependents may elect to continue coverage as described in the **Federal Continuation Provision (COBRA)** section of this Description of Benefits.

All coverage ends on the day coverage terminates. Procedures must be fully completed prior to termination of the coverage to be considered for benefit.

Federal Continuation Provision (COBRA)

Continued Dental Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to self-pay for continued dental coverage in certain circumstances where your coverage through a group dental plan would otherwise end. This section outlines your continued dental coverage rights under the COBRA legislation.

Qualifying Event for Continued Coverage

A qualifying event is an occurrence causing a covered employee, spouse or dependent to lose group dental coverage, qualifying them for continued coverage under the COBRA extension.

Continued Coverage for Employees

Continued coverage is an option for employees if any of the following qualifying events occurs:

1. Termination of employment, voluntary or involuntary, except for reasons of gross misconduct.
2. Reduction of hours.

Continued Coverage for the Spouse of an Employee

Continued coverage for the spouse of an employee is an option if coverage is lost because any of the following qualifying events occur:

1. Death of the spouse-employee.
2. Termination of the spouse-employee's job for other than gross misconduct.
3. Reduction of the spouse-employee's hours.
4. Divorce or legal separation from the spouse-employee.
5. Enrollment of the spouse-employee in Medicare.

Continued Coverage for a Dependent Child

Children born to or adopted by an employee while the employee is on COBRA continuation coverage are eligible for COBRA continuation coverage as dependents of the employee. Continuation coverage for a dependent child of an employee is an option if any of the following qualifying events occur:

1. No longer a *dependent child* as defined by this dental plan.
2. Death of the parent-employee.
3. Termination of the parent-employee's job for other than gross misconduct.
4. Reduction of the parent-employee's hours.
5. Divorce or legal separation of the parents.
6. Parent-employee is enrolled in Medicare.
7. The child is born to or adopted by the employee while the employee is on continued coverage.

Length of Continued Coverage

Your dental care coverage may continue according to the following schedule:

- 18 months:** If qualifying event is job termination or reduction of hours.
- 29 months:** For qualified beneficiaries who are totally disabled under Social Security either at the time of the qualifying event or during the first 60 days of COBRA continuation coverage.
- 36 months:** For all other qualifying events.

Notification Process

Your employer will advise Delta Dental if you lose coverage under this dental plan due to one of the qualifying events listed. Your human resources department will notify you of your self-pay options and the dental plan's monthly costs. You will then have up to 60 days to decide whether to purchase continued coverage.

If your spouse or dependent child loses coverage due to one of the qualifying events listed, the person seeking the coverage extension must notify your employer. This individual will be informed of his or her self-pay options and will have 60 days from the qualifying event or notice of the qualifying event to decide whether to purchase the coverage.

Termination of Continued Coverage

Continued coverage following a qualifying event is a right provided by COBRA legislation. It is important to note, however, that continued dental coverage can be terminated for any of these reasons:

1. An individual fails to make a timely premium payment, given the grace period provided by the group contract.
2. The employer ceases to offer a group dental plan.
3. Coverage begins under another group dental plan as a result of employment or remarriage.
4. An individual enrolls in Medicare after electing COBRA continuation and then becomes qualified for Medicare.
5. A qualified beneficiary finds new coverage, unless the new coverage contains a pre-existing condition limitation that affects the benefits available to the qualified beneficiary under the new coverage.

A person with continued dental coverage who finds new coverage with a pre-existing limitation will be allowed to maintain the continued coverage even though he or she is otherwise covered by a new dental plan.

If you have any questions about continued dental benefits, the human resources department at your company should be able to help you.

Date: 12/09/2011

III. Claims Procedures

PRIOR APPROVAL OF BENEFITS

Your group dental plan does not require prior approval of dental procedures. However, you or your dentist may request a Predetermination of Benefits to obtain advance information on your group dental plan's possible coverage of dental procedures before they are rendered. Payment, however, is limited to the benefits that are covered under your plan and is subject to any applicable deductibles, copayments, coinsurance, waiting periods, and annual and lifetime benefit maximums.

HOW TO CONTEST A CLAIM DENIAL

Denial of a Claim for Benefits

If you make a claim for benefits under this group dental plan and your claim is denied in whole or in part, you and your dentist, will receive written notification within 30 days after your claim is received, unless special circumstances require an extension of time for processing. The decision will be sent on a form entitled "Explanation of Benefits."

If additional time is necessary for processing a claim for benefits, Delta Dental will notify you and your dentist of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either you or your dentist did not submit information necessary to make a benefits determination, the notice of extension will describe the required information. You will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact Delta Dental at **800-236-3712**. Because most questions about benefits can be answered informally, Delta Dental encourages you first to try resolving any problem by talking with them. However, you have the right to file an appeal requesting that Delta Dental formally review the benefits determination.

To file a grievance or appeal a benefits determination, contact Delta Dental's Benefit Services Department at **800-236-3712**, fax your request to **715-343-7616**, or mail your request to Delta Dental, P.O. Box 828, Stevens Point, WI 54481. Provide the reasons why you disagree with the benefits determination and include any documentation you believe supports your claim. Be sure to include the subscriber's name, the covered dependent's name if applicable, and the subscriber's social security number on all supporting documents.

Delta Dental will acknowledge your written request for review within 5 days of receiving it. Upon your request, you will be provided, free of charge, access to and copies of all documents, records, and other information relevant to your claim for benefits.

Within 30 days of receiving your request, you will be sent a written decision and indicate any action taken. (Special circumstances may require 60 days.)

You have the right to appear in person before Delta Dental's Grievance Committee to present written and oral information and ask questions of the persons responsible for the determination that resulted in the grievance. We will provide you with written notice of the meeting place and time at least 7 days before the meeting.

Delta Dental will provide you or your authorized representative with written notice of the decision on the appeal. If the appeal is denied in whole or in part, that notice will include the following information.

1. The specific reason(s) for the denial of the appeal;
2. Reference to the specific Plan provision(s) on which the denial is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim;
4. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;
5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;
6. If the denial of the appeal was based on a dental necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you do not exhaust the appeal procedures described above, and if you file a lawsuit seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize Delta Dental's grievance/claims appeal procedures. Also, no legal action can be brought against Delta Dental later than 3 years after the date of the Grievance Committee's final decision on the review of the benefits determination.

If you have any questions, please contact:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
800-236-3712 or 715-344-6087

IV. Statement of ERISA Rights

As a covered person in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all covered persons in the Plan shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

Continue Group Health Plan Coverage

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

Prudent Action By Plan Fiduciaries

In addition to creating rights for covered persons under the Plan, ERISA imposes duties upon the people who are responsible for the operation of the 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 covered persons and beneficiaries. No one, including the employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

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 from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan 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

Plan 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.