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I. Plan Description Information

1. Plan Name: Marquette University Group Dental Plan

2. Plan Sponsor: Marquette University

3. Plan Administrator and Named Fiduciary:

   Marquette University
   915 W Wisconsin Ave
   PO Box 1881
   Milwaukee WI 53201-1881
   414-288-7305

4. Plan Sponsor’s Employer Identification Number (EIN): 39-0806251
   The Plan number assigned for government reporting purposes is 501.

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, 2014.

7. The Plan year is January 1 – December 31.
   The Fiscal year is July 1 – June 30.

8. Agent for service of legal process:

   Octavio Castro
   Marquette University
   915 W Wisconsin Ave
   PO Box 1881
   Milwaukee WI 53201-1881

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. Retirees who participate in the Plan will pay 100% of the premium for their coverage under the Plan.

11. Each employee and retiree who participate 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 to provide your dental benefits administration. All of us at Delta are pleased to provide this service to you and your family.

Your Choice of Dentists

Delta Dental PPO is a preferred provider option. This dental plan offers an added benefit to patients receiving treatment from a Delta Dental PPO Dentist.

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 on the 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! And because these dentists agree to fees approved by Delta, they receive payment directly from Delta.

Dentists Outside the Delta Dental PPO Network

**Delta Dental Premier Dentists**

Dentists who have signed a contract with Delta Dental have agreed to accept direct payment from Delta. They have also agreed not to charge you any amount that exceeds the fees agreed upon, aside from deductibles, copayments, and fees for procedures not covered.

**Noncontracted Dentists**

If your dentist has not signed a contract with Delta Dental, claim payments will still be calculated on Delta’s Maximum Plan Allowance (MPA), but they will be sent directly to you rather than to the dentist. You will then need to reimburse your dentist through his or her usual billing procedure.

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 dentists, call 800-236-3712, or visit Delta’s web site 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 Social Security number. We accept any standard claim form and will provide claim forms to your dentist on request.

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 orthodontics, 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

In all cases where you select a more expensive service or benefit than is customarily provided, or for which Delta Dental does not believe a valid need is shown, Delta will pay the applicable percentage of the fee for the service that would be adequate to restore the tooth or dental arch to contour and function. You are then responsible for the remainder of the dentist’s fee.

Clerical or Administrative Error

If a clerical error or other administrative mistake occurs, that error will not deprive you of coverage under your dental Plan that you would otherwise have had. A clerical error or other administrative mistake also will not create coverage for you under your Plan if coverage does not otherwise exist.
Summary of Benefits

Group Number: 90507

Effective Date of Program: January 1, 2010

Dependents to the end of the month they reach age 19; full-time students to the end of the month they reach age 25. Graduating students are covered to the end of the month in which they graduate.

Deductibles:

Per Person, per Benefit Accumulation Period: $ 50.00
Per Family, per Benefit Accumulation Period: $150.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period: $2,500.00 **
Orthodontic Maximum Benefit:
Per Person, per Lifetime: $2,000.00

**There is no annual Benefit maximum applied to Diagnostic and Preventive Services.

Benefits:
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.

Other dentists not listed on the Delta Dental PPO Dentist list or Delta Dental Premier list will charge you any balance of their fee remaining after Delta’s payment. Payment is based on the lesser of the dentist’s fee or the Maximum Plan Allowance (MPA).

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<tr>
<th>Procedure</th>
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<td>Diagnostic and Preventive Procedures</td>
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<td>Basic Restorative Procedures</td>
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<tr>
<td>Major Restorative Procedures</td>
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</tr>
<tr>
<td>Orthodontic Procedures</td>
<td>60%*</td>
</tr>
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</table>

Orthodontics is a benefit for employee, spouse and dependent children to age 19, full-time students to age 25.

* Deductible applies.
Any covered dental expenses incurred in the last three months of a calendar year which is applied to that year's deductible will be carried forward to apply to the satisfaction of the next year's deductible.

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.

**Marquette University Dental School:**

The Plan limits apply, including maximum plan allowance (MPA). However, deductibles and co-insurance are waived when services are rendered by Marquette University Dental School and its satellite clinics.

The deductible is waived when services are rendered by a Marquette University faculty provider and Basic Restorative Procedures coinsurance is 90%, Major Procedures Procedures 80%.

**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.

**Evidence-Based Integrated Care Plan (EBICP)**

Delta Dental’s Evidence-Based Integrated Care Plan (“EBICP”) is an enhancement that provides expanded benefits for persons with diseases and medical conditions that have oral health implications. To participate in EBICP, eligible dental Plan enrollees or their Dentists are required to set the appropriate health condition indicator online at www.deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin.

The EBICP benefits are as follows:

**Periodontal Disease**

1. With an indicator of surgical or non-surgical treatment of Periodontal Disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of surgical or non surgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

**Diabetes**

1. With an indicator of **Diabetes** diagnosis, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

**Pregnancy**

1. With an indicator of **Pregnancy**, a participant is eligible for one additional dental visit for adult prophylaxis or periodontal maintenance during the pregnancy.

**High Risk Cardiac Conditions**

1. With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:
   - History of infective endocarditis
   - Certain congenital heart defects (such as having one ventricle instead of the normal two)
   - Individuals with artificial heart valves
   - Heart valve defects caused by acquired conditions like rheumatic heart disease
   - Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
   - Individuals with pulmonary shunts or conduits
   - Mitral valve prolapse with regurgitation (blood leakage)

**Suppressed Immune System Conditions**

1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

**Kidney Failure or Dialysis Conditions**

1. With an indicator for **Kidney Failure or Dialysis Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
Cancer Related Chemotherapy and/or Radiation

1. With an indicator for Cancer Related Chemotherapy and/or Radiation, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of Cancer Related Chemotherapy and/or Radiation, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

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.
7. Topical application of sealants for dependents to age 19. Applications limited to the occlusal surface of molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.
8. Emergency treatment to relieve pain.

Basic Restorative Procedures

1. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.

2. a. Amalgam (silver) restorations — 1 placement per tooth surface in a 1-year period;
   b. composite (tooth-colored) restorations — 1 per tooth surface in a 1-year period;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.
3. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
4. Endodontics (root canal treatment and root canal fillings) — 1 per tooth in a 2-year period.
5. 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 prophylaxis — either periodontal prophylaxis or adult prophylaxis twice per calendar year, after completion of periodontal therapy.
6. Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a benefit once in any 24-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. a. Prosthetics (fixed bridgework, partial or complete dentures, or implants to replace missing permanent teeth);
   b. porcelain veneers on crowns or pontics;
   c. 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;
   d. fixed bridges and partial or complete dentures, or implants where chewing function is impaired due to missing teeth. A fixed bridge, or implant, and implant related procedures may be a benefit if no more than two teeth are missing in the dental arch in which the bridge or implant is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch. 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

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; 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

Benefits are coordinated when more than one plan provides dental coverage for you and your dependents. If you or your family members have dental benefits under other group plans, Delta Dental will coordinate allowable expenses from this dental plan with them. An allowable expense is a necessary, reasonable and customary charge for an item covered at least partly by one or more plans covering the person making the claim.

When another plan is primary, Delta Dental is the secondary plan. Depending on the benefit you have already received and what your other plan covers, you may receive up to 100% benefit between the two plans, but not more than that.

As the secondary plan, Delta Dental calculates your benefit as if there were no other plan. Then we subtract what the other plan paid, taking deductibles and copayment levels for the benefit into consideration. The difference between what we pay as the secondary plan and what we would have paid as the primary plan is available to pay for allowable expenses incurred but not paid in a calendar year for the person making the claim.

Determining Which Plan is Primary:

When a husband and a wife work for different firms, they may have coverage under two group plans. The plan covering the patient as the employee has responsibility for providing benefits before the plan covering the patient as a dependent.

If the patient is a dependent child, the plan of the parent whose birth date is earlier in the calendar year (month and day only) is primary.

If the patient is a dependent child of separated or divorced parents and two or more plans cover the child, the plan of the parent with custody of the child is primary. The plan of a spouse of the parent with custody of the child is secondary, and lastly the plan of the parent not having custody.

If a court decree states that parents have joint custody of a child but does not say which parent is responsible for the child’s health care expenses, or if it says that both parents are responsible but gives physical custody to one parent, benefits for the child are determined by the rules just described. But if a court decree states that one parent is responsible for the child’s health care expenses, the benefits of that parent’s plan are determined first.

The benefits of a plan covering a person as an active employee (neither laid off nor retired) or as such an employee’s dependent are determined before those of a plan covering the person as inactive (laid off or retired) or as such an employee’s dependent. If another plan does not have this rule and this results in a disagreement on which plan is primary, this rule is ignored. If you have continuation coverage under federal or state law and are also covered under another plan, the benefits of a plan covering you as an employee, member or subscriber or as a dependent of an employee, member or subscriber are determined first, then the continuation coverage next. If another plan does not have a continuation coverage rule and this results in a disagreement on which plan is primary, this rule is ignored.
Eligibility

Covered Employees:

You are covered by this Delta Dental plan while you are a regular full-time eligible employee of the group. A regular full-time eligible employee is eligible for benefits on the date of hire. An eligible employee is a person who is classified by the employer on both payroll and personnel records as an employee who works full time:

· Nonbargaining person, regularly scheduled to work for the Plan Sponsor on a full-time basis for at least 37 ½ hours a week or have a similar academic appointment; or

· Bargaining person, regularly scheduled to work for the Plan Sponsor for at least 30 hours a week; or

· Regularly scheduled to work for the Plan Sponsor on a part-time basis for at least 80 hours a month/minimum of 1,000 hours per year; or

· Full-time temporary, minimum of a 1 calendar/academic year contract.

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

· Temporary or leased employees.

· An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as may be defined in this SPD.

· A consultant who is paid on other than a regular wage or salary by the employer.

· A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees with such reclassification, shall change a person's eligibility for benefits.

Note: Eligible employees and dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or dental insurance policy. Proof of such plan or policy may be required upon application for special enrollment.
You may also be covered by this dental plan if you no longer meet the eligibility condition 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 legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act or your domestic partner who is a person of the same sex with whom you have established a Domestic Partnership provided your spouse or domestic partner is not covered as an employee under this Plan. All references to the spouse of an employee shall include a domestic partner. An eligible dependent does not include an individual from whom you have obtained a legal separation or divorce unless court ordered. Documentation on a Covered Person's marital status or domestic partner status may be required by the Plan Administrator.

2. Any dependent child of the employee until the child reaches his or her 19th birthday. The term "child" includes the following dependents who meet the eligibility listed below:

   o A natural biological child;

   o A step child;

   o A legally adopted child or a child legally placed for adoption as granted by action of a federal, state, or local government agency responsible for adoption administration or a court of law if the child has not attained age 18 as of the date of such placement;

   o A child under your (or your spouse's) legal guardianship as ordered by a court;

   o A child who is considered an alternate recipient under a Qualified Medical Child Support Order.

**Eligibility Criteria:** To be an eligible dependent child, the following conditions must all be met:

   o A dependent child must reside with the employee. The residency requirement does not apply to children who are full-time students living away from home to attend school, to children who reside in an institution, or to children who are enrolled in accordance with a Qualified Medical Child Support Order because of the employee's divorce or separation decree.

   o A dependent child must legally qualify to be claimed as a tax exemption on the employee's or spouse's federal income tax return. A step child must also reside with the employee and be dependent upon the employee for principal support and maintenance.

   o A dependent child must be unmarried.
Any person who is covered as an eligible employee shall not also be considered an eligible dependent under this Plan. An eligible child will not be covered if the child is covered as a dependent of another employee at this company. Dependents in military service are not covered by this dental plan. Employees have the right to choose which eligible dependents are covered under the Plan.

**Extended Coverage for Dependent Children**
Coverage under this Plan may be extended for a dependent child if the following conditions are met:

- The dependent child was covered by this Plan on the day before the child's 19th birthday, and

- A covered dependent child who is attending high school or an accredited institution of higher education as a full-time student will continue to be eligible until the end of the month in which the child turns age 25, until the end of the month in which the child graduates, or until the end of the month in which the child no longer attends school as a full-time student, whichever is earlier. The Plan may require proof of the dependent child's full-time student enrollment on an as-needed basis. A full-time student who finishes the spring term shall be deemed a full-time student throughout the summer if the student has enrolled as a full-time student for the following fall term, regardless of whether or not such student enrolls for the summer term.

- If you have a dependent child covered under this Plan who is under the age of 19 and totally disabled, either mentally or physically, or if the child is over age 19 and is a full time student and eligible for coverage at the time of the disability, that child's dental coverage may continue beyond the day the child would cease to be a dependent under the terms of this Plan. You must submit written proof that the child is totally disabled within 31 calendar days after the day coverage for the dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue as long as the dependent child is deemed to be totally disabled subject to the following minimum requirements:
  - The dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof must be submitted as required; and
  - The employee must still be covered under this 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.
Domestic Partnership:

A relationship between an employee and one other person of the same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a domestic partner of, another person under either statutory or common law.
- They must share a common residence and common necessities of life.
- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.

The employee and domestic partner must be registered with and recognized as domestic partners in the state that they reside. In the case where an employee and his or her domestic partner reside in a state that does not have a registry, the employee and domestic partner must jointly sign an affidavit of Domestic Partnership.

Effective Dates of Coverage:

If you apply within 30 days of hire, you are covered by this dental plan beginning on the first day this dental plan becomes effective or on your date of hire.

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

Leave of Absence and Family and Medical Leave Act

An employee may retain eligibility for coverage under this Plan if the employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis.

If an employee is on leave as provided by the Family and Medical Leave Act (FMLA), your share of the cost must be paid using one of three methods: pay in advance, pay-as-you-go, or catch-up contributions upon return to work. If you elect not to return to work for at least 30 days at the end of the leave period, you will be required to reimburse the employer for the cost of the dental benefits paid by the employer for maintaining coverage during the unpaid leave, unless you cannot return to work because of a serious health condition or circumstances beyond your control. If you fail to return to work on the originally scheduled return date, you will be deemed to have voluntarily terminated employment. Dental benefits will terminate on the last day of the leave.

Coverage will be continued for up to the greater of:

- The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or
The leave period required by applicable state law.

**Changes in Coverage:**

You may change your enrollment in this dental plan if there is a qualifying event. Qualifying events include a loss of other dental coverage or a change in family status such as a person who becomes your eligible dependent through marriage, birth, adoption, or placement for adoption. 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 earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or

- The date this Plan is canceled; or

- The date coverage for your benefit class is canceled; or

- The last day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at open enrollment periods. If you voluntarily terminate your employment from the 1st - 15th of the month, your coverage will end at the end of the month. If you voluntarily terminate on the 16th of the month or after, your coverage will end the last day of the following month; or

- The last day of the month in which you tell the Plan to cancel your dependent's coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at open enrollment periods; or

- The last day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling it while remaining eligible; or

- The last day of the month in which you are no longer a member of a covered class, or notice/severance payment expires, as determined by the employer except if you are temporarily absent from work due to active military duty; or
· The last day of the month in which your employment or coverage ends; or

· The last day of the month in which your dependent is no longer your legal spouse due to legal separation or divorce, as determined by the law of the state where the employee resides; or

· The last day of the month in which your dependent child attains the dependent age limitation shown on the Summary of Benefits page, unless the dependent child qualifies for a medically necessary leave of absence; or

· The last day of the month in which the dependent becomes covered as an employee under this Plan; or

· The date dependent coverage is no longer offered under this Plan; or

· The date you or your dependent submits a false claim or are involved in any other form of fraudulent act related to this 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. It is your responsibility to notify the group of any loss of coverage. All coverage ends on the day coverage terminates. Procedures must be fully completed prior to termination of the coverage to be considered for benefit.

Extension of Coverage

When this Plan terminates dental coverage, all benefits stop, except benefits for operative procedures in progress on the termination date. Benefits will continue for bridges, partials and complete dentures completed within 60 days after the termination date. Benefits will continue for root canals, crowns and inlays/onlays completed within 31 days after the termination date. These are considered in progress only if procedures for laboratory work are completed before your coverage terminates. Benefits are payable for operative procedures only if they would have been payable had your coverage not terminated. You have up to 90 days after your termination date to submit claims for these Extended Benefits.

Reinstatement of Coverage

If your coverage ends due to termination of employment, leave of absence or lay-off and you later return to active work, you must meet all requirements of a new employee. Refer to the information on Leave of Absence and Family and Medical Leave Act for possible exceptions, or contact your Human Resources or Personnel office.
Federal Continuation Provision (COBRA)

**Important.** Read this entire provision to understand your COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides you with general notice of your rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to you as required.

**The COBRA Administrator for this Plan is: Employee Benefits Corporation**

**INTRODUCTION**
Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person’s coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage triggers COBRA.

Generally, you, your covered spouse, and dependent children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

**COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES**
The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because either one of the following Qualifying Events happens:

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Length of Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your employment ends for any reason other than your gross misconduct</td>
<td>up to 18 months</td>
</tr>
<tr>
<td>Your hours of employment are reduced</td>
<td>up to 18 months</td>
</tr>
</tbody>
</table>

(There are two ways in which this 18 month period of COBRA continuation coverage can be extended. See the section below entitled “Your Right to Extend Coverage” for more information.)
If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Length of Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your spouse dies</td>
<td>up to 36 months</td>
</tr>
<tr>
<td>Your spouse’s hours of employment are reduced</td>
<td>up to 18 months</td>
</tr>
<tr>
<td>Your spouse’s employment ends for any reason other than his or her gross misconduct</td>
<td>up to 18 months</td>
</tr>
<tr>
<td>Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)</td>
<td>up to 36 months</td>
</tr>
<tr>
<td>You become divorced or legally separated from your spouse</td>
<td>up to 36 months</td>
</tr>
</tbody>
</table>

The dependent children of an employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Length of Continuation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The parent-employee dies</td>
<td>up to 36 months</td>
</tr>
<tr>
<td>The parent-employee’s hours of employment are reduced</td>
<td>up to 18 months</td>
</tr>
<tr>
<td>The parent-employee’s employment ends for any reason other than his or her gross misconduct</td>
<td>up to 18 months</td>
</tr>
<tr>
<td>The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)</td>
<td>up to 36 months</td>
</tr>
<tr>
<td>The parents become divorced or legally separated</td>
<td>up to 36 months</td>
</tr>
<tr>
<td>The child stops being eligible for coverage under the plan as a dependent</td>
<td>up to 36 months</td>
</tr>
</tbody>
</table>

COBRA continuation coverage for retired employees and their dependents is described below:

- If you are a retired employee and your coverage is reduced or terminated due to your Medicare entitlement, your spouse and dependent children will also become Qualified Beneficiaries.
- If you are a retired employee and your employer files bankruptcy under Title 11 of the United States Code this can be a Qualifying Event. If it results in the Loss of Coverage under this Plan, then the retired employee is a Qualified Beneficiary. The retired employee’s spouse, surviving spouse and dependent children will also be Qualified Beneficiaries if bankruptcy results in their Loss of Coverage under this Plan.

**COBRA NOTICE PROCEDURES**

**ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION**

To be eligible to receive COBRA continuation coverage, covered employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrators, either your employer or the COBRA Administrator.

**Effective: 01-01-2010**

A Qualified Beneficiary’s written notice must include all of the following information: (A form to notify your COBRA Administrator is available upon request.)

- The Qualified Beneficiary’s name, their current address and complete phone number,
- The group number, name of the employer that the employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

EMPLOYEE BENEFITS CORPORATION  
1350 DEMING WAY STE 200  
CLIENT LIAISON  
MIDDLETON WI 53562-3536

Customer service phone # is 800-346-2126  
Fax: 806-831-4790  
Website is www.ebcflex.com

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect your family’s rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT
Your employer will give notice when coverage terminates due to Qualifying Events that are the employee’s termination of employment or reduction in hours, death of the employee, or the employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT
You must give notice in the case of other Qualifying Events that are divorce or legal separation of the employee and a spouse, a dependent child ceasing to be covered under a plan, or a second Qualifying Event. The covered employee or Qualified Beneficiary must provide written notice to your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

Once you have provided notice of the Qualifying Event, then your employer will notify the COBRA Administrator within 30 calendar days from that date.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered employee or the Qualified Beneficiary.
MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that you must complete if you wish to elect to continue your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If you do not choose COBRA continuation coverage within the 60-day election period, your group health coverage will end on the day of your Qualifying Event.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that you receive on or after the date you lose coverage due to a Qualifying Event. If, however, you decide to elect COBRA continuation coverage, your group health coverage will be reinstated back to the date you lost coverage, provided that you properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If your employer offers annual enrollment opportunities for active employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for dependents). The cost of continuation coverage will be adjusted accordingly.

The initial payment is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated, up to the time you make the first payment. If the initial payment is not made within the 45-day period, then your coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for subsequent payments is typically the first day of the month for any particular period of coverage, however you will receive specific payment information including due dates, when you become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.
If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then you will be required to reimburse the Plan for the benefits received.

**NOTE:** Payment will not be considered made if a check is returned for non-sufficient funds.

**YOUR NOTICE OBLIGATIONS WHILE ON COBRA**
Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause you or your dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary gets married.
- The date a child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- The date the COBRA Administrator or the Plan Administrator requests additional information from you. You must provide the requested information within 30 calendar days.

**LENGTH OF CONTINUATION COVERAGE**
COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- **For Employees and Dependents.** 18 months from the Qualifying Event if due to the employee’s termination of employment or reduction of work hours. (If an active employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and dependent children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the employee’s termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)

- **For Dependents only.** 36 months from the Qualifying Event if coverage is lost due to one of the following events:
  - Employee’s death.
  - Employee’s divorce or legal separation.
  - Former employee becomes enrolled in Medicare.
  - A dependent child no longer being a dependent as defined in the Plan.

- **For Retired Employees and Dependents of Retired Employees only.** If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum
period, subject to all COBRA regulations. The covered retired employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or dependent child of the covered retired employee can continue coverage until the earlier of:
  ➢ The date the Qualified Beneficiary dies; or
  ➢ The date that is 36 months after the death of the covered retired employee.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE
While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the required timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): In the event that you are determined by the Social Security Administration to be disabled, you may be eligible for up to 29 months of COBRA continuation coverage.

You must give the COBRA Administrator the Social Security Administration letter of disability determination within 60 days of the later of:

  • The date of the SSA disability determination;
  • The date the Qualifying Event occurs;
  • The date the Qualified Beneficiary loses (or would lose) coverage; or
  • The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Second Qualifying Events: (Dependents Only) If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or dependent children if the employee or former employee dies, becomes entitled to Medicare (Part A, Part B or both) or is divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent. These events will only lead to the extension when the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

You must provide the notice of a second Qualifying Event within a 60-day period that begins to run on the latest of:

  • The date of the second Qualifying Event; or
  • The date the Qualified Beneficiary loses (or would lose) coverage; or
  • The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.
EARLY TERMINATION OF COBRA CONTINUATION
COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any employees. (Note that if the employer terminates the group health plan that you are under, but still maintains another group health plan for other similarly-situated employees, you will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).
- The required contribution for the Qualified Beneficiary’s coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition(s) for the beneficiary.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If You Are Thinking Of Declining COBRA Continuation Coverage)
If you think you might need to get an individual health insurance policy soon, then electing COBRA continuation coverage now may protect some of your rights. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, you must elect COBRA continuation coverage under this Plan and maintain it (by paying the cost of coverage) for the duration of your COBRA continuation period. In the event that you need an individual health insurance policy, you must apply for coverage with an individual insurance carrier after you have exhausted your COBRA continuation coverage and before you have a 63-day break in coverage.

If you think you will be getting group health coverage through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if you have less than a 63-day break in health coverage (Creditable Coverage).

HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC)
The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance. Trade adjustment assistance is generally available to only a limited group of individuals who have lost their jobs or suffered a reduction in hours as a result of import competition or shifts of production to other countries. Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit

Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage during a special second election period (if the employee did not elect COBRA coverage already). The special second COBRA election period lasts 60 days or less, beginning on the first day of the month in which the employee becomes an eligible HCTC recipient, but the election must also be made within six months after the initial loss of group health coverage. As a result, if the employee finds out that he or she is eligible for this program with fewer than 60 days remaining in the six month period after initial loss of group health coverage, then this second election period will be less than 60 days. The employee must send the COBRA Administrator a copy of the confirmation letter from HCTC or the State Workforce Agency, stating the effective date of eligibility under this program.

COBRA coverage elected during the special second election period is not retroactive. Coverage begins on the date that the special second election period begins, and the maximum COBRA coverage period will end on the same day it would have ended if COBRA coverage had been elected during the regular 60-day election period. There is no retroactive coverage for the gap period from the initial Loss of Coverage to the first day of the special second election period. For example, if an Employee's coverage ends on June 30 due to termination of employment, and the employee elects COBRA coverage during a second 60-day election period that begins on November 1, the person would have no coverage from July 1 to October 31. COBRA coverage would start on November 1 and would end 14 months later because the maximum COBRA coverage period would expire 18 months from Loss of Coverage due to termination of employment. For purposes of Pre-Existing Condition exclusions, the Plan will not count any days between the initial loss of group health coverage and the first day of the special second election period as part of a 63-day Significant Break in Coverage.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the employee, the spouse of a covered employee or the dependent child of a covered employee. This includes a child who is born to or Placed for Adoption with a covered employee during the employee’s COBRA coverage period if the child is enrolled within the Plan’s enrollment provision for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered employee.
- Voluntary or involuntary termination of the covered employee’s employment (other than for gross misconduct).
- A reduction in work hours of the covered employee.
- Divorce or legal separation of the covered employee from the employee’s spouse. (Also, if an employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost
coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- The covered former employee becomes enrolled in Medicare.
- A dependent child no longer being a dependent as defined by the Plan.

**Loss of Coverage** means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

**American Recovery and Reinvestment Act of 2009 (COBRA Subsidy)**

**Note:** This provision will automatically terminate on 12-31-2011, and benefits outlined will no longer be available without further Plan amendment.

The American Recovery and Reinvestment Act of 2009 (ARRA), as amended by the Department of Defense Appropriations Act of 2010 (“Defense Act”), reduces the COBRA premium in some cases. If a Covered Person experienced a Loss of Coverage due to involuntary termination by the employer during the period that begins with September 1, 2008 and ends with February 28, 2010, the Covered Person may be eligible for the temporary premium reduction for up to fifteen months.

**Eligible Individuals**

Covered Persons and their dependents who experienced a Loss of Coverage under the Plan due to an involuntary termination of employment between September 1, 2008 and February 28, 2010 and as a result, fit the definition of Qualified Beneficiary under COBRA are eligible. These individuals may also be referred to as Assistance Eligible Individuals (AEIs).

Some AEIs will have declined COBRA prior to passage of the law or elected COBRA but then dropped coverage prior to passage of the law. These AEIs will have a second opportunity to elect COBRA coverage and take advantage of the premium subsidy (reduced premium).

Some AEIs who have exhausted their 9 month subsidy period prior to December 19, 2009 and who failed to pay the premium during the transition period may be eligible to retroactively reinstate coverage provided that they pay the reduced premium for such coverage within 60 days of the date of the enactment (in which case the due date would be February 17, 2010) or if later, 30 days after the date the notice is provided. The transition period is any period of coverage that begins prior to December 19, 2009 and is subject to the extension.

In addition, any AEI who exhausted their 9 month subsidy period prior to the date of enactment of the “Defense Act”, and then subsequently paid the full premium during the transition period
(the period of coverage that begins prior to December 19, 2009) are entitled to a refund or credit as prescribed by the original ARRA legislation.

Assistance Eligible Individuals must not be eligible for coverage under any other group health plan (other than certain limited plans). This includes eligibility for coverage under a spouse’s employer’s plan or Medicare. Failure to notify the Plan of eligibility under any other group health plan can result in significant penalties.

The subsidy will be phased out starting with taxpayers whose modified adjusted gross income exceeds $125,000 ($250,000 in the case of a joint return). This means a percentage of the subsidy will be recaptured in the federal income taxes imposed on individuals making more than $125,000 ($250,000 in the case of a joint return). Higher income individuals $145,000 ($290,000 in the case of a joint return) can make an election to waive the subsidy in the manner and form set forth by the Secretary of the Treasury.

**AMOUNT AND LENGTH OF SUBSIDY**

Assistance Eligible Individuals will be responsible for only 35% of the amount of their COBRA premium. That means a Qualified Beneficiary whose normal full COBRA premium would be $500 per month would be responsible for paying only $175 per month for the qualifying time period.

The subsidy period ends at the earliest following date:

- Fifteen months after the date the individual becomes eligible for the subsidy.
- The Qualified Beneficiary becomes eligible for coverage under any other group health plan (other than certain limited plans) or becomes eligible for Medicare. This also includes eligibility for coverage under a spouse’s employer’s plan. The Qualified Beneficiary must notify the administrator in writing of such eligibility as set forth by the Department of Labor (DOL). Failure of the Qualified Beneficiary to notify the administrator may result in a penalty of 110% of the premium reduction provided after termination.
- The Qualified Beneficiary’s maximum period of continuation coverage required under the applicable COBRA continuation coverage provision is met. Note that for those Qualified Beneficiaries receiving a second opportunity to elect coverage, the maximum COBRA continuation coverage period runs from the original Qualifying Event.

**ELECTING THE SUBSIDY**

If you have a Qualifying Event between September 1, 2008 and February 28, 2010 your COBRA Administrator will send you a formal notification of your COBRA rights under the American Recovery and Reinvestment Act. The notification will include the necessary forms and instructions on how to elect to receive the subsidy as applicable.

If it is determined that you are not an AEI, and you disagree with this determination, you may appeal this determination with the DOL in the manner and form specified by them. Please see http://www.dol.gov/ebsa/subsidydenialreview.html. State and local government Employees should contact HHS-CMS at www.cms.hhs.gov/COBRAContinuationofCov/ or NewCobraRights@cms.hhs.gov.
If you have any questions about your rights to COBRA continuation coverage, you should contact

EMPLOYEE BENEFITS CORPORATION
1350 DEMING WAY STE 200
CLIENT LIAISON
MIDDLETON WI 53562-3536

Customer service phone # is 800-346-2126
Fax: 608-831-4790
Website is www.ebcflex.com

HEALTH COVERAGE TAX CREDIT (HCTC)
The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. ARRA made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011 and temporary extensions of the maximum period of COBRA continuation coverage for PBGC recipients (covered employees who have a nonforfeitable right to a benefit any portion of which is to be paid by the PBGC) and TAA-eligible individuals.

If you have questions about these provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Date: 11/26/2013
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
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 Employee Benefits Security 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 excising 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 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.