DENTAL COM INSURANCE PLAN, INC.

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MEMBER HANDBOOK

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DENTAL COM INSURANCE PLAN, INC.

MEMBER HANDBOOK

MARSHFIELD CLINIC HEALTH SYSTEM, INC.
FAMILY HEALTH CENTER, INC.
LAKEVIEW MEDICAL CENTER, INC.
MARSHFIELD CLINIC, INC.

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DENTAL COM INSURANCE PLAN, INC.
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INTRODUCTION

The best thing you can do for your teeth is to take care of them regularly, before a serious problem occurs. Dental Com Insurance Plan, Inc. encourages regular, preventive dental care. The program emphasizes diagnostic and preventive services designed to minimize the possibility of future dental disease. This means better dental health for you and your family.

Your coverage permits a participant to choose only from among the dentists at the Dental Clinic of Marshfield, S.C.

Please read this booklet carefully so you are familiar with Your Dental Plan and keep it in a handy place for reference.

This Member Handbook is a brief summary of the insurance Policy between DENTAL COM and Your Group. The Master Group Policy ("Policy") governs the Benefits and limitations of Your coverage. You may review the Policy during normal business hours if You desire. Please call Your Group or DENTAL COM.

DEFINITIONS

When used and capitalized in this Member Handbook or any amendments or riders attached hereto, the terms listed below are defined as follows:

1. **Benefits**. Under the Policy, Benefits include the Dental Service and Emergency Service as described in the Plan Benefit Summary.

2. **Charge**. A Charge is the usual, customary, and reasonable fee or cost for a Dental Service. Fees are usual, customary and reasonable if they do not exceed the cost usually charged by the individual rendering the service or the general level of fees for similar services charged by others within the community where rendered, taking into consideration the complexity of treatment required for the particular case. No agreement as to the fee between You and a person, firm or corporation providing or rendering services shall increase the liability of DENTAL COM to pay more than the usual, customary, and reasonable fee.

3. **Dental Com Insurance Plan, Inc**. Dental Com Insurance Plan, Inc. is a Wisconsin corporation located in Marshfield, Wisconsin and affiliated with Dental Clinic of Marshfield. It will be referred to as DENTAL COM in this Member Handbook.

4. **Dental Clinic Dentist**. A Dental Clinic Dentist means a Dentist who is employed by, associated with or engaged by Dental Clinic of Marshfield.

5. **Dental Service**. Dental Service means those professional services of a Dental Clinic Dentist that are generally and customarily prescribed except as expressly limited or excluded by the Policy.

6. **Dentist**. A Dentist is someone who is licensed as a Doctor of Dental Surgery or its equivalent and who is a professional practitioner authorized by law to practice dentistry.

7. **Effective Date**. Your Effective Date is the date on which You become covered for Benefits.

8. **Emergency**. A serious dental condition caused by dental disease or accident that arises suddenly. If not treated immediately, an Emergency would result in jeopardy to Your dental health.

9. **Emergency Service**. The services described as Emergency Service in the Plan Benefit Schedule.

10. **Grievance**. Any dissatisfaction with DENTAL COM, the Primary Provider, the administration, claims practice or services provided under the Policy, expressed in writing by You or on Your behalf.

11. **Group**. The Group is the employer through which You have this coverage.

12. **Laboratory Charges**. Laboratory Charges are any charges incurred by a Dental Clinic Dentist or charged to the Dental Clinic Dentist by a dental laboratory. Laboratory Charges are charged for the preparation and fabrication of space maintainers, all indirect restorations, prosthetic appliances, or the repair of the above.

13. **Member**. A Member is an employee (whether single or married) of the Group who is reported as eligible for Benefits under the Policy and for whom the proper fees have been paid.

14. **Out of Area Services**. Services rendered at a location outside the Service Area.

15. **Participant**. A Participant means any Member or his or her Dependents.

16. **Policy**. The Policy is the agreement by DENTAL COM to provide Benefits to the Group and includes the application You submitted to the Group and any supplements, amendments, endorsements or riders attached to the Policy.

17. **Service Area**. The Service Area is a 60-mile radius of Marshfield, Wisconsin and includes the counties of Wood, Clark, Portage, Marathon and Taylor.

18. **You(r)**. The Member and his or her enrolled Dependents, unless specifically stated that "You" refers only to a Member or Dependent.

QUALITY IMPROVEMENT SUMMARY

DENTAL COM has established a quality improvement committee that identifies, evaluates and seeks to improve processes related to access to care and quality of care.

Through a series of project and process management activities, all staff members are involved with the implementation of our quality improvement initiatives. Additionally, Members play a vital role in improving the quality of care. Please bring any problems or complaints to our attention immediately.

RIGHTS AND RESPONSIBILITIES OF PARTICIPANTS

Participant Rights

Right To Choose
You have the right to choose a Dentist from which You will receive services from among Dental Clinic of Marshfield's Dentists.

Right To Information
You have the right to information on Your dental plan relating to:

- Covered and excluded dental Benefits
- Available general and specialty care providers
- Preventive care

- Your condition and its related care
- The process to make known a complaint or request, and
- Policies and procedures relevant to Your care.

Right To Privacy and Confidentiality
You have the right to privacy and confidentiality of all communications and records on Your care.

Right To Be Treated with Respect and Dignity
You have the right to be treated with respect and dignity regardless of Your race, age, sex or creed.

Right To Participate in Your Care
You have the right to be active in decisions about Your treatment. You have the right to a candid discussion of appropriate or dentally necessary treatment options for Your condition, regardless of cost or benefit coverage. You have the right to be informed about the risks and benefits of treatment and to refuse care.

Right To Present a Complaint or Grievance
You have the right to voice concerns about Your care and to receive a prompt and fair review of Your complaints. You have the right to courteous and attentive treatment.

Participant Responsibilities

You Must Know Your Benefits and Requirements
You have a responsibility to:

- Understand Your dental plan Benefits,
- Follow the required procedures, and
- Ask questions about things You do not understand.

You Must Provide Accurate Information
You have a responsibility to provide accurate and complete information about Your health and dental history and Your eligibility and enrollment. You have a responsibility to fulfill any financial obligations You may incur on the day You receive services.

You Should Participate in Your Care
You have a responsibility to participate in Your care by:

- Asking questions to understand Your condition,
- Following the recommended or agreed upon, treatment plan for Your condition, and

- Making healthy lifestyle choices to try to maintain Your oral health and prevent illness.

You Must Keep Your Appointments
You have a responsibility to keep Your appointments or to give early notice (minimum of four (4) hours) if You must reschedule or cancel an appointment.

You Must Show Consideration and Respect
You have a responsibility to show consideration and respect to health care providers and staff.

BROKEN APPOINTMENTS

The time that the Dentist sets aside for a patient is very valuable. Broken appointments are more than just an inconvenience or a discourtesy; they greatly add to the expense of the program. Other patients could have been scheduled for needed dental care. The delay may also require more complex procedures, at a greater expense to You, the Dentist and the program.

Therefore, if You break an appointment without at least four (4) hour's notice, the Dentist may charge a fee for the block of time reserved. This fee is not covered under the Policy.

ELIGIBILITY

AN ELIGIBLE MEMBER:
is an employee (whether single or married) of the Group who is reported by the Group as eligible for Benefits under the Policy.

A FAMILY DEPENDENT IS:

1. The Member's lawful spouse.
2. The Member's child until the end of the month they turn 26.

   A child continues to be an eligible Dependent beyond the limiting age above if he or she is unable to support himself or herself due to mental retardation or physical handicap. You must send DENTAL COM a Doctor's certification of disability at least 31 days before the child reaches the limiting age and as often as DENTAL COM requests for the following 2 years. After that, DENTAL COM may request proof of disability annually.

3. Any child of a Dependent child (the Member's grandchild) until the Dependent child reaches the age of 18.

4. Your adult child who:
   (a) Was under 27 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 attending, on a full-time basis, an institution of higher education;
   (b) Applied to an institution of higher education as a full-time student within 12 months of the date they fulfilled the active duty obligation and remains a full-time student;
   (c) Is not married; and
   (d) Is not eligible for coverage under a group health benefit plan that is offered by their employer and for which the amount of their premium contribution is no greater than the premium amount for their coverage as a Dependent under this Policy.

DENTAL COM may require documentation confirming satisfaction of the criteria set forth in section 4 above; provided that DENTAL COM may only require such evidence when the child first qualifies and not more frequently than annually thereafter.

ENROLLMENT

INITIAL ENROLLMENT PERIOD: At the time the Group is initially enrolled, each Member shall complete a DENTAL COM application form. The Effective Date for Members enrolled during the initial enrollment period is the date the Policy begins.

SUBSEQUENT ENROLLMENT PERIOD: Employees not participating under the Policy may enroll or existing Members may terminate their coverage only during a subsequent enrollment period. The time period to enroll shall be as indicated each calendar year by the Group.

NEW EMPLOYEES: New employees of the Group and their Dependents may enroll within 31 days of the date the employee first becomes eligible for coverage. If the employee properly enrolls and the required premium is paid, the Effective Date for new employees and their Dependents is the first of the month following the date of eligibility.

NEW DEPENDENTS:

1. MARRIAGE. Dependents who become eligible due to marriage may enroll within 31 days of the marriage date. If such Dependents are properly enrolled and the applicable premium is paid within such timeframe, the Effective Date for such Dependents is the date of the marriage.

2. NEWBORN CHILDREN. A Member's newborn child will be covered from the date of birth provided DENTAL COM is notified by the Group of the birth and the Member pays the additional premium within sixty (60) days of the date of birth**.**

   If no additional premium is required to enroll the child, the newborn child will be covered as of the date of birth. DENTAL COM requests that the Member notify the Group as soon as possible of the new Dependent.

3. ADOPTED CHILDREN. An adopted child or child placed with the Member for purposes of adoption will be covered from the date of the final decree of adoption or date of placement if any required premium is paid and the Group is notified within sixty (60) days after the date of adoption or placement.

CHANGES IN MEMBERSHIP STATUS. You should notify Your Group as soon as possible of any change of address or in Your membership status resulting from marriage, divorce, separation, death, birth or the adoption of a child.

You are eligible to receive treatment as of Your Effective Date. To schedule an appointment, please call the number assigned to the center of Your choice.

You also have the right to change Your Dental Clinic Dentist at any time, for whatever reason, as long as the Dental Clinic Dentist has the expertise necessary to provide the care you need.

CLAIM PROCEDURES

1. **Definitions**.

   "Urgent care claim" is a claim where waiting the standard time for a benefit decision could seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of a physician with knowledge of Your condition, would subject You to severe pain that cannot be adequately managed without the care requested.

2. **Proof of Loss.** We must be given written proof of a loss for which a claim is made. This proof must cover the occurrence, character and extent of the loss. The proof must be furnished within ninety (90) days after the date of the loss, otherwise the claim will not be considered valid. However, if it is not reasonably possible to meet such time limit, the claim will still be considered valid if the proof is furnished as soon as reasonably possible, and within one year after it was required by the Policy.

   If You fail to properly follow our procedure for filing a pre-service claim, we will notify You within five (5) days of the proper procedure. If the claim is an urgent care claim, we will notify You within twenty-four (24) hours.

3. **Initial Determinations.**

   a. Urgent Care Claims.

      If Your claim is an urgent care claim, we will provide You with a decision as soon as possible, taking into account your medical circumstances, but not later than seventy-two (72) hours after receipt of Your claim. However, if we require additional information from You to make the benefit determination, we will make such a request within twenty-four (24) hours of receipt of Your claim. You will have forty-eight (48) hours to provide the requested information. We will reach a decision as soon as possible but not later than forty-eight (48) hours from:

      (1) the receipt of the additional information from You, or

      (2) the end of the forty-eight (48) hours You had to provide the information

      whichever occurs first. If we deny Your claim and communicate the denial to You orally, You will receive a written notice within three (3) days. Our denial will include all the elements listed in part d.

   b. Concurrent Care Decisions.

      We may approve an ongoing course of treatment to be provided over a period of time or a number of treatments.

      If we have approved an ongoing course of treatment and we determine that such treatment

should be reduced or terminated before the end of the period of time or number of treatments authorized, we will inform You enough time in advance to appeal our decision. The notice will include all the elements listed in part d. If Your appeal to continue treatment is an urgent care claim and if the claim is received at least twenty-four (24) hours before the expiration of the previously approved time period for treatment or number of treatments, we will make a determination as soon as possible, taking into account your medical circumstances, but not later than twenty-four (24) hours after receipt of Your claim. If your claim is not an urgent care claim or is filed less than twenty-four (24) hours before the expiration of the previously approved time period for treatment or number of treatments, we will respond according to the type of claim involved.

c. Other Claims.

All other initial determinations shall be made within a reasonable period of time, but not later than thirty (30) days after the date the claim was received by us.

d. Claim Denials.

If we deny Your claim, in whole or in part, we will inform You in writing. The denial notice will include all of the following:

(1) The specific reason(s) for the denial.

(2) Reference to the specific plan provision on which the denial is based.

(3) A description of any additional information needed to complete the claim and an explanation of why the information is necessary.

(4) A description of Your right to appeal, including the deadline and procedures, and Your right to bring a civil action under ERISA if the appeal is not decided in Your favor.

(5) If we used a specific internal guideline to make our determination, a statement that we relied on such guideline and that You may obtain a copy of the guideline free of charge, upon request.

(6) If the determination is based on a dental determination, such as that the procedure is

not a dental necessity or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your dental condition.

(7) If Your claim involves urgent care, a description of our expedited review process.

4. **Grievance Procedure.**

You will be notified of Your right to file a Grievance and the procedure to follow each time a claim or benefit is denied. This includes a refusal to refer You for additional services, or when disenrollment proceedings are initiated. The notification will state the specific reason for the denial or initiation of disenrollment proceedings. The Grievance procedure is outlined below.

In the event that You have a complaint or problem regarding services under the Policy, You should submit Your Grievance in written form to DENTAL COM'S Grievance committee. The Grievance committee will acknowledge the Grievance in writing within five (5) business days of receipt.

If Your Grievance is an appeal of an urgent care claim, You may request an expedited Grievance. You should call 1-715-387-1702 and state that You would like an expedited Grievance.

You have the following rights with respect to Your Grievance:

a. The right to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

b. The right to submit written comments, documents, records and other information relating to Your claim.

c. The right to appear before the Grievance committee to present written or oral information and to question the person who made the initial determination that resulted in the Grievance. The Grievance committee shall notify You of the date and time of the committee meeting at least seven (7) calendar days before the meeting is scheduled.

The Grievance committee will conduct a full and fair review of Your claim, without considering the initial determination. The committee will not include the person who originally denied the claim or that person's subordinate. If the claim requires a dental judgment, the committee will consult with a dental professional who has the appropriate training and experience in the field of dentistry involved in the dental judgment. If a dental professional was consulted in making the initial determination, the dental professional consulted on appeal will not be the same person or that person's subordinate. Upon request, we will provide You with the names of the dental or vocational experts consulted to reach a determination.

The Grievance committee will provide You with a written decision within the following timeframes:

a. Urgent care claim: As quickly as Your condition requires, but no later than within seventy-two (72) hours of receipt of the Grievance.

b. Post-service claim: Within thirty (30) days of the date we originally received the Grievance. If there are special circumstances that require an extensive review, the final decision will be made within sixty (60) calendar days of receipt of the Grievance. We will notify You if we need additional days, the reason for the delay and the date that You might expect a decision.

c. Concurrent care claim: Within seventy-two (72) hours of receipt of an urgent care claim; thirty (30) days if the claim involves a pre-service claim; and sixty (60) days if the claim involves a post-service claim.

The committee's written decision will notify You of the result of Your Grievance and any corrective action taken. The decision will be signed by a member of the committee and include the position titles of the committee members.

If the Grievance committee denies Your appeal, in whole or in part, the written decision will include all of the following:

a. The specific reason(s) for the denial.

b. Reference to the specific plan provision on which the denial is based.

c. A statement that You are entitled to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

d. A statement of Your right to bring a civil action under the Employee Retirement Income Security Act of 1974 ("ERISA").

e. If the Grievance committee used a specific internal guideline to make the determination, a statement that it relied on such guideline and that You may obtain a copy of such guideline free of charge, upon request.

f. If the determination is based on a dental determination, such as that the procedure is not a dental necessity or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your dental condition.

You may resolve the Grievance by taking the steps outlined above. You also may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the **Office of the Commissioner of Insurance** by writing to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Or You can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

5. **Authorized Representative.**

Your authorized representative may act on Your behalf in pursuing a claim or Grievance. Unless one of the exceptions listed below applies, You must submit a statement in writing that the representative is authorized to act on Your behalf and may receive Your confidential information. We have a form available that You may use to appoint an individual as Your authorized representative.

We will not require written authorization if any of the following applies:

a. The person is authorized by law to act on Your behalf.

b. You are unable to give consent and the person is a spouse, family member or the treating provider.

c. The Grievance is an expedited Grievance and the person represents that You have verbally authorized the person to represent You.

GENERAL CONDITIONS

1. **Dentist/Participant Relationship**. Nothing in the Policy shall interfere with the professional relationship between You and Your attending Dentist.

2. **Evidence of Participation**. You must present Your identification card, or otherwise make the fact of Your participation known, to the Dental Clinic Dentist when applying for Benefits.

3. **Release of Information**. You expressly consent to, authorize and direct any Dentist or other person or corporation by whom or in which dental, medical or surgical treatment is being considered or has been rendered, to release any records or other information, or copies thereof, as DENTAL COM may request for purposes of payment or operations.

4. **Subrogation**. Whenever DENTAL COM has been or is providing Benefits because of an injury or sickness for which a third party may be liable, DENTAL COM may make a claim or maintain an action against the third party for damages, reimbursement or payment to the extent of the value of Benefits received or to be received.

   By accepting Benefits from DENTAL COM relating to an injury or sickness, You assign to DENTAL COM the right to make a claim against the third party to the extent of the value of Benefits rendered.

   You and DENTAL COM agree to join the other in making a claim against the third party or commencing an action.

   To the extent required by law, DENTAL COM shall seek to recover proceeds from You only after You have been wholly or fully compensated for the damages arising from the injury or sickness.

   DENTAL COM has the right to recover amounts representing its subrogation interests under this

provision through any appropriate legal or equitable remedy, including but not limited to, the initiation of a collection action under ERISA or applicable federal or state law, intervention in legal action initiated by You, the imposition of a constructive trust or the filing of a claim for equitable restitution against any recipient of monies recovered through settlement, judgment or otherwise.

You must not do anything after the loss to prejudice any rights of DENTAL COM or of the Group to recovery. You must promptly advise DENTAL COM and the Group in writing whenever a claim against a third party is made with respect to any loss for which Benefits were, or are being, received from DENTAL COM.

Nothing contained in this section shall limit the ability or right of the Group to make a claim or maintain an action against the third party for recovery.

5. **Monetary Value of Benefits**. When it is necessary to determine the monetary value of Benefits provided to You under the Policy, such value shall be the charges that would have been made if the Policy were not in effect.

6. **Non-Assignment of Benefits**. No person other than You is entitled to Benefits under this Policy. Rights under this Policy are not assignable or transferable in any manner. Rights shall be forfeited if You or any other person assigns, transfers or aids any other person improperly in obtaining Benefits hereunder.

7. **Limitation of Actions**. You may not start an action or suit, at law or in equity, to recover Benefits under the Policy until at least sixty (60) days after a claim has been filed with DENTAL COM in writing or DENTAL COM denies the claim, whichever is earlier. No action shall be commenced more than three years from the time the written proof of loss is required to be furnished to DENTAL COM.

8. **Obligation of DENTAL COM**. DENTAL COM shall in no way be responsible for any act or omission of any Primary Provider, Dental Clinic Dentist, professional practitioner or their agents, to supply Dental Services. The obligation of DENTAL COM shall be limited solely to providing Benefits according to the provisions in the Policy.

9. **Reimbursement**. You agree to reimburse DENTAL COM for any Benefits paid or provided for which You were not eligible under the terms of the Policy. Such reimbursement shall be due and payable immediately upon notification and demand to You by DENTAL COM.

10. **Misrepresentations**. Fraudulent misstatements by You shall void Your coverage and serve as the basis for denials of claims for Benefits.

11. **Dual Coverage**. If You are eligible for Benefits under more than one DENTAL COM Policy, You shall be entitled to an allowance therefore equal to the Charges for the aggregate Benefits available under such DENTAL COM Policies, up to, but not exceeding, the total incurred regular Charges for all Dental Services.

COORDINATION OF BENEFITS

1. APPLICABILITY. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan, except to the extent this provision is superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

   If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

   a. shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the section "Effect on the Benefits of This Plan."

2. DEFINITIONS.

   a. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care, including Dental Services [and Orthodontic Services], when the item of expense is covered at least in part by one or more 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 service rendered shall be considered both an Allowable Expense and a benefit paid.

b. "Claim Determination Period" means a calendar year. However, 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.

c. "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. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program. Each Policy or other arrangement for coverage under (1) or (2) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

d. "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 This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

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.

e. "This Plan" means the part of the Group Policy that provides Benefits for Dental Service expenses.

3. ORDER OF BENEFIT DETERMINATION. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its Benefits determined after those of the other Plan, unless:

   a. the other Plan has rules coordinating its benefits with those of This Plan; and

   b. both those rules and This Plan's rules described below require that This Plan's Benefits be determined before those of the other Plan.

4. RULES. This Plan determines its order of benefits using the first of the following rules that applies:

   a. Non-dependent/Dependent. The benefits of the Plan that covers the person other than as a Dependent are determined before those of the Plan that covers the person as a Dependent.

   b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph c., when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

      (1) 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 that calendar year; but

      (2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

      However, if the other Plan does not have the rule described in (1) 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.

c. 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:

(1) first, the Plan of the parent with custody of the child;

(2) then, the Plan of the spouse of the parent with the custody of the child; and

(3) 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 health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule b. above.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the 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.

d. Active/Inactive Employee. The benefits of a Plan that 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 that 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 d. is ignored.

e. Continuation Coverage. 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 person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

(2) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. 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 that covered that person for the shorter time.

5. EFFECT ON THE BENEFITS OF THIS PLAN.

a. When This Section Applies. This Section applies when, in accordance with the Section "Order of Benefit Determination", This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

b. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(1) the Benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(2) the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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.

6. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. DENTAL COM has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Dental and medical records remain confidential as provided by state and federal law. Each person claiming Benefits under This Plan must give DENTAL COM any facts it needs to pay the claim.

7. FACILITY OF PAYMENT. A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, DENTAL COM may pay that amount to the organization that made that payment. That amount will then be treated as though it was a Benefit paid under This Plan. DENTAL COM 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.

8. RIGHT OF RECOVERY. If the amount of the payments made by DENTAL COM is more than it should have paid under this COB provision, it may recover the excess from one or more of:

   a. the persons it has paid or for whom it has paid;

   b. insurance companies; or

   c. other organizations.

   The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allows a Participant to continue coverage beyond the date it would normally end. An employer may be required to comply with the minimum requirements of COBRA. It is the intent of this Policy to comply with the minimum legislative requirements and be coextensive with COBRA. In the event the law is amended and such amendment affects a provision herein, such provision shall be deemed modified to

comply with such amendment and this Policy shall be administered accordingly. It shall be the Group's responsibility to determine which provision(s) apply to the Group.

1. **Qualified Beneficiaries.** You are a Qualified Beneficiary if:

   a. You are a Member or Dependent who was covered by the Policy on the day before the Qualifying Event.

   b. You are a child born to, or adopted by or placed for adoption with a Member during a period of COBRA continuation. You must otherwise be eligible for coverage and the Member must enroll you on a timely basis in accordance with the terms of the Policy.

   c. You are a retired Member or the retired Member's spouse, surviving spouse or Dependent child and a Qualifying Event described in 2e below causes You to lose coverage under the Policy.

2. **Qualifying Events.** A Qualifying Event is one of the following events that would otherwise cause the Qualified Beneficiary to lose coverage within the Maximum Continuation Period:

   a. Termination of the Member's employment (for any reason other than gross misconduct), or reduction in the Member's work hours.

   b. Death of the Member.

   c. Legal separation or divorce from the Member.

   d. Loss of eligibility by a Dependent child due to the termination of Dependent status.

   e. A Chapter 11 bankruptcy filing by a Group.

3. **Maximum Continuation Period.** The Maximum Continuation Period following a Qualifying Event is:

a. Eighteen (18) months from the date of a Qualifying Event stated in 2a above.

A Participant may extend this 18-month period as follows:

(1) Member Entitlement to Medicare. If the Member is entitled to Medicare at the time of an initial Qualifying Event, then the period of continuation for covered Dependents is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the Qualifying Event.

(2) Total Disability. The 18 months may be extended up to a total of 29 months from the original Qualifying Event for a Qualified Beneficiary who was Social Security disabled at the date of the Qualifying Event or within the first 60 days of continuation coverage.

(3) Second Qualifying Event. The 18 (or 29) months may also be extended up to a total of 36 months from the original Qualifying Event, if during the initial 18 (or 29) months of continuation, one of the Qualifying Events described in 2b through 2d above occurs that would otherwise have caused covered Dependents to lose coverage.

b. Thirty-six (36) months after the date of a Qualifying Event stated in 2b through 2d above.

c. If the Qualifying Event is a Group's bankruptcy filing as stated in 2e above,

the following periods apply for the following Qualified Beneficiaries:

(1) A retired Employee is covered for life.

(2) A retired Employee's spouse and Dependent children are covered for the retiree's life and if they survive the retiree, for thirty-six (36) months after the retiree's death.

(3) If the retired Employee is deceased at the time of bankruptcy and the Policy covers the surviving spouse, then the surviving spouse is covered for life.

4. **Termination.** COBRA continuation coverage will terminate on the earliest of the following dates:

a. The last day of the period for which the Participant has made a timely premium payment.

b. For a disability extension, the first of the month which is more than 30 days after the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

c. The date the Qualified Beneficiary first becomes covered, after the COBRA election has been made, under another group health plan provided the Qualified Beneficiary's coverage under the other group plan is not limited due to a preexisting condition limitation applicable to such Qualified Beneficiary.

d. The date the Qualified Beneficiary first becomes entitled to Medicare, after the COBRA election has been made.

e. The Group termination date.

f. The date the Maximum Continuation Period expires.

5. **Employer Notification of Qualifying Events.** The Member's employer must notify the Group's COBRA administrator of a Member's death, employment termination or reduction in work hours or entitlement to Medicare.

6. **Participant Notification of Qualifying Events.** The Participant must notify the Group's COBRA administrator in writing of the following events:

a. Divorce/Legal Separation. Within sixty (60) days of the later of (1) the date of divorce or legal separation from the Member; or (2) the date that the Participant would otherwise lose coverage due to this event.

b. Child Loses Eligibility. Within sixty (60) days of the later of (1) the date that a covered Dependent child loses eligibility (e.g., due to age, loss of student status, marriage, etc.); or (2) the date that the Dependent child would otherwise lose coverage due to this event.

c. Social Security Disability Extension. Within sixty (60) days after the latest of:

(1) The date of the Social Security Administration's disability determination;

(2) The date of the Member's termination of employment or reduction of hours; or

(3) The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Policy as a result of the Member's termination of employment or reduction of hours.

The notice also must be provided before the expiration of the original 18 month continuation period.

d. Second Qualifying Event. Within sixty (60) days of the later of: (1) the date of the occurrence of a second Qualifying Event (i.e., divorce, legal separation, Member entitlement to Medicare, or child loss of eligible Dependent status); or (2) the date the Qualified Beneficiary would otherwise lose coverage due to the event if the Qualified Beneficiary had still been covered under the Policy.

e. COBRA Notice Procedures. Notice of the above events must be provided to the Group's COBRA administrator in writing at the following address:

Marshfield Clinic Health System, Inc.
Benefits Manager, Human Resources Office
1000 North Oak Avenue
Marshfield WI 54449

The notice must contain the following information:

(1) The plan name;

(2) The Group name;

(3) The Member or former Member's name and address;

(4) The names of all Qualified Beneficiaries who lost coverage due to the event;

(5) The type of event;

(6) The date of the event;

(7) The signature, name and address of the individual sending the notice;

(8) For divorce or legal separation, a copy of the decree of divorce or legal separation; and

(9) For disability extensions, a copy of the Social Security Administration's determination of disability.

Oral notice is unacceptable. Failure to provide proper written notice on a timely basis will result in loss of all rights to continuation of coverage.

7. **Election Notice.** After receiving notice of a Qualifying Event, the Group's COBRA administrator will notify a Participant of the right to elect continuation of coverage. Notice to the Member or the Member's covered spouse is considered notice to all Qualified Beneficiaries residing with the Member or Member's covered spouse.

8. **Qualified Beneficiary Notification of Loss of Eligibility for Continuation.** A Qualified Beneficiary must notify the Group's COBRA administrator, in writing, within thirty (30) days of either of the following events:

    a. Medicare or Other Group Plan Coverage. If, after electing COBRA, a Qualified Beneficiary becomes entitled to Medicare (Part A or Part B, or both) then the Qualified Beneficiary is no longer eligible for COBRA. If, after electing COBRA, a Qualified Beneficiary becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the Qualified Beneficiary have been exhausted or satisfied), then the Qualified Beneficiary is no longer eligible for COBRA.

        COBRA coverage will terminate as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. Termination may be retroactive. The Qualified Beneficiary must repay the Plan for all benefits paid after the termination date, regardless of whether or when the Qualified Beneficiary provided notice of Medicare entitlement or other group health plan coverage.

    b. Termination of Social Security Disability. If the Social Security Administration

issues a determination that a Qualified Beneficiary is no longer disabled, then continuation coverage terminates on the first of the month which is more than 30 days after the Social Security Administration determines that he/she is no longer disabled. The Qualified Beneficiary must repay all benefits paid after the termination date, regardless of whether or when he/she provides notice that Social Security has determined that his/her disability has ended.

The written notice must include the plan name, the Group name, the Member or former Member's name, the type of event, the name(s) of any other Qualified Beneficiary affected by the event and the name, address and signature of the Qualified Beneficiary who submits the notice.

9. **Election Period.** A Participant will be given a period of sixty (60) days to elect COBRA coverage. The Group's COBRA administrator will send the Participant an election form to complete and return. If a Participant initially rejects COBRA, the Participant may change his/her mind as long as the sixty (60) day election period has not expired. The election period begins on the later of:

   a. The date coverage terminates.

   b. The date the Group's COBRA administrator notifies the Participant of his/her right to elect continuation coverage.

   A terminated Member or the Member's spouse can elect coverage on behalf of all Qualified Beneficiaries in the family. If the terminated Dependent is a minor, his/her parent or guardian may act on his/her behalf. All Qualified Beneficiaries in a family have individual election rights.

10. **Special Considerations for COBRA Election.** In considering whether to elect COBRA, a Participant should take into account that a failure to elect COBRA will affect future rights under federal law. First, the Participant can lose the right to avoid having preexisting condition

exclusions applied to the Participant by other group health plans if the Participant has more than a sixty-three (63) day gap in health coverage. Election of COBRA may help the Participant not have such a gap. Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if the Participant does not get COBRA coverage for the maximum time available. Finally, the Participant should take into account that he/she has special enrollment rights under federal law. The Participant has the right to request special enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participant's spouse's employer) within thirty (30) days after the Participant's group health coverage under the Plan ends because of the qualifying event listed above. The Participant will also have the same special enrollment right at the end of COBRA coverage if the Participant gets COBRA coverage for the maximum time available.

11. **Premiums and Payments.**

a. Amount. The premium charged may not exceed 100% of the Group rate then in effect. If a Qualified Beneficiary's coverage continues beyond eighteen (18) months because of disability, the premium in the nineteenth (19) through twenty-ninth (29) months may be 150% of the Group rate. The Participant must make premium payment by check.

b. Initial Payment. If the Participant elects COBRA, he/she does not have to send any payment with the election form. However, the Participant must make his/her initial payment for COBRA coverage not later than forty-five (45) days after the date of the election. (This is the date the election form is postmarked, if mailed, or the date the election form is received at the address specified for delivery of the election form, if hand-delivered.) If the Participant does not make his/her initial payment for COBRA coverage in full within forty-five (45) days after the date

of his/her election, the Participant will lose all COBRA rights under the Plan.

The Participant's initial payment must cover the cost of COBRA coverage from the time his/her coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the Participant makes his/her first monthly payment. The Participant is responsible for making sure that the amount of his/her initial payment is correct. The Participant may contact the Group's COBRA administrator to confirm the correct amount of his/her initial payment.

Claims for reimbursement will not be processed and paid until the Participant has elected COBRA and made his/her first COBRA payment.

c. Monthly Payments. After the Participant makes his/her initial payment for COBRA coverage, the Participant will be required to make monthly payments for each subsequent month of COBRA coverage. The Group's COBRA administrator will inform the Participant of the amount due for each month for each Qualified Beneficiary. Under the Plan, each of these monthly payments for COBRA coverage is due on the 15th day of the month for the next month's COBRA coverage. The Group's COBRA administrator will not send periodic notices of payments due for these coverage periods. It is the Participant's responsibility to pay COBRA premiums on time. If the Participant makes a monthly payment on or before the 15th day of the month, the Participant's COBRA coverage under the Plan will continue for the next month without any break.

Although monthly payments are due on the 15th day of the prior month to continue COBRA coverage for the next month, the Participant will be given a grace period of thirty (30) days from the

first day of the month of coverage to make each monthly payment. The Participant's COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

However, if the Participant makes a monthly payment later than the due date, but before the end of the grace period, the Participant's coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim the Participant submits for benefits while his/her coverage is suspended may be denied and may have to be resubmitted once the Participant's coverage is reinstated.

If the Participant fails to make a monthly payment before the end of the grace period for that month, he/she will lose all rights to COBRA coverage under the Policy.

d. Where to Make Payments. The Participant's initial payment and all monthly payments for COBRA coverage should be mailed or hand-delivered to the Group's COBRA administrator as follows:

Security Health Plan Inc.
PO Box 8000
Marshfield WI 54449

If mailed, the Participant's payment is considered to have been made on the date that it is postmarked. If hand-delivered, the Participant's payment is considered to have been made when it is received at the address specified above. The Participant will not be considered to have made any payment by mailing or hand-delivering a check if his/her check is returned due to insufficient funds or otherwise.

TERMINATION

1. **Termination by Group**. If the Policy terminates for any reason, Your rights to Benefits under the Policy shall terminate immediately.

2. **Termination of Member**. Your rights to Benefits under the Policy shall terminate at the end of the period for which the Group paid the last Fee Deposit to DENTAL COM.

3. **Termination of Dependent**. A Dependent's rights to Benefits under the Policy shall automatically cease at the end of the month in which he ceased to be a Dependent or at the end of the period for which the last premium payment was paid to DENTAL COM by the Group, if earlier.

4. **Service After Termination**. Except as otherwise provided in the Policy, in the event any services are required by You or are performed on Your behalf after Your rights to Benefits have terminated, the expenses incurred for such care shall be Your full responsibility.

DISENROLLMENT

DENTAL COM may disenroll You, resulting in termination of coverage, for any one of the reasons described below:

1. You fail to pay required premiums within 31 days after the due date.

2. You permit someone else to use the enrollment identification or knowingly provide fraudulent information in applying for coverage or receiving services.

3. You pose a threat to providers or other Members of the plan because of physical or verbal abuse.

4. You are unable to establish or maintain a satisfactory provider-patient relationship with a Primary Provider. Disenrollment only will occur after DENTAL COM has provided You with an opportunity to select an alternate provider, has made reasonable efforts to assist You in establishing a satisfactory provider-patient relationship, and has provided You with notice of the right to file a Grievance.

5. You move outside the Service Area.

If You are disenrolled, You may appeal DENTAL COM's decision by filing a Grievance. DENTAL COM will arrange alternative dental coverage for You if You are disenrolled until the earlier of: a) the date You find alternative coverage or b) the date You have an opportunity to change plans.

EXCLUSIONS AND LIMITATIONS

No Benefits will be paid for:

1. Dental services not specifically described in the Policy as Dental Services and Emergency Services.

2. Dental or emergency service for congenital malformations or for cosmetic or aesthetic purposes, except that the Plan will replace congenitally missing teeth with removable or fixed bridge work.

3. Bleaching of teeth for purely cosmetic reasons.

4. Laboratory charges.

5. Replacement of crowns (except for temporary or stainless steel crowns) unless at least five (5) years have elapsed since the date of the initial insertion.

6. A personalized appliance or one involving specialized techniques beyond what is necessary to eliminate oral disease and restore missing teeth, if a satisfactory result can be achieved through the utilization of standard procedures and materials. The balance of cost for the selected appliance or technique shall be the responsibility of the Member.

7. Replacement of an existing removable partial denture, full denture or fixed bridge by a new removable partial denture, full denture or a fixed bridge, or addition of teeth to an existing removable partial denture or bridge unless at least five (5) years have elapsed since the date of the initial insertion of that appliance.

8. Charges for any duplicate prosthetic device or any other duplicate appliance including orthodontic appliances whether lost, stolen or damaged. (If, upon enrolling in this Plan, the

Participant's existing bridge or denture is not satisfactory in the sole opinion of the Dental Clinic, the Plan will pay for its replacement minus the actual cost of any lab fees).

9. Dental or emergency service which, if this Policy were not in effect: would be furnished to the Participant without charge; the Participant would be entitled to have furnished or paid for fully or partially under any law, regulation or agency of any government; or the Participant would be entitled, or would be entitled if s/he were enrolled, to have furnished or paid for under any voluntary medical or dental plan established by any government.

10. Dental or emergency service for, or resulting from injuries, disease or conditions for which the Participant receives, or would have been eligible had benefits been applied for, any award or settlement under a Workers' Compensation Act or any Employer Liability Law or Occupational Disease Act or Law.

11. Dental Service provided after the date the Participant ceases to be covered except for the following:

    – Procedures commenced prior to and completed in one visit within 31 days following termination of coverage (e.g., root canal or crown). These are procedures that have been started while the Policy is in effect and are completed in one visit after coverage is terminated.
    – Prosthetic devices which are ordered and fitted prior to, and completed within 60 days following termination of coverage.

12. Any charges for Dental Service received at a dental facility other than the Dental Clinic of Marshfield, S.C., except for Emergency Services.

13. Implants and implant prosthetics.

14. Hospital or physician services of any kind whether or not related to covered services.

15. IV sedation.

16. Charges for treatment of or services related to temporomandibular joint dysfunction.

17. Hospital or physician services of any kind whether or not related to covered Dental Services.

18. Dental Service and Emergency Service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of this Policy and caused by atomic explosion whether or not the result of the war.

19. Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit set forth in Article VI.

20. Dental Service and Emergency Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.

21. If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the Participant selects a more complicated treatment (precision attachments or fixed bridgework), Benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the Participant.

22. Periodontal treatment done exclusively for esthetic purposes.

23. Any service related to:

    a. altering vertical dimension;

    b. restoration of occlusion-bruxism, generalized tooth wear (no full mouth restorations);

    c. splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth;

d. bite registration or bite analysis;

24. Any service, or a related service, which is a benefit under a hospital and/or surgical-medical group benefit plan offered by the same Group that covers the Member.

25. Sleep apnea/snoring appliances.

BENEFITS

The Benefits available to You are the Dental Services and Emergency Service set forth in the attached Plan Benefit Summary.

Plan Benefit Summary

The Dental Com Plan has no yearly dollar maximum or deductible. The following dental care services are covered at 100% except as noted otherwise:

Diagnostic

- Routine oral examinations and prophylaxis (cleaning of teeth) twice every 12 months per covered individual.
- Dental x-rays including full mouth x-rays once every 5 years, supplemental bitewing x-rays twice every 12 months, and such other dental x-rays as are needed for diagnosis and treatment of a specific condition.

Preventive

- Topical fluoride treatment
- Space maintainers that replace prematurely lost primary teeth.
- Oral hygiene, plaque control and dietary instruction
- Topical application of sealants. Application is limited to the occlusal surface of permanent molars which are free of caries and restorations. Replacement of sealants shall be covered until the age of 18.
- Initial placement of sealants on posterior permanent teeth within two (2) years of their eruption. Replacement of sealants shall be covered until the age of 18.

The following dental care services are covered at 90% except as noted otherwise*:

Patients should check with the Patient Accounts staff prior to the appointment, or the cashier on the day of the appointment at the Dental Clinic of Marshfield, S.C. regarding fees due. **Fees must be paid in full on the date services are received.**

Ancillary (supplementary)

- Nitrous oxide sedation

Emergency

- Emergency care at a dental facility outside of the service area is limited to $100
- Emergency palliative treatment (relief of pain)

- Emergency denture repairs and adjustments. The participant also pays the laboratory charges.

Restorative

- Filing restorations of diseased or broken teeth. Materials used to restore teeth will be amalgam, composite or plastic.

***Posterior composite restorations:** if a satisfactory result can be obtained with an amalgam restoration, but the member and Doctor select composite, the benefit is limited to the amount of the amalgam restoration, the member pays the difference.

- Specific Inlays, Onlays, and Crowns to restore diseased or broken teeth when the tooth cannot be restored by the methods described above. The participant also pays the laboratory charges.

The following dental care services are covered at 90% except as noted otherwise*:

Patients should check with the Patient Accounts staff prior to the appointment, or the cashier on the day of the appointment at the Dental Clinic of Marshfield, S.C. regarding fees due. **Fees must be paid in full on the date services are received.**

- **Crowns and bridges:** porcelain, premium porcelain, porcelain w/ gold, premium porcelain w/ gold, non and semi precious porcelain and full cast gold will require a co-payment for all laboratory charges. Contact Patient Accounts prior to your appointments to obtain fee estimates for these services.

Oral Surgery

- Oral surgery not already covered by your group health policy.
- Oral surgery for extraction of erupted and impacted wisdom teeth is covered by the participant's group health plan. Refer to plan summaries for affiliated provider listings and deductibles.

Endodontics

- Root Canal Anterior, Bicuspid, Molar, Endodontic Retreatment, Apicoectomy – Anterior, Biscuspid, Molar, Pulp Capping.

***Certain endodontic procedures** are not a covered benefit under the plan. Please check with Patient Accounts prior to your appointment regarding fees due.

Periodontics

- Treatment, not already covered by your group health policy, of periodontal diseases of the gums and supportive tissues of the teeth.

Certain surgical and non-surgical periodontal services (i.e. bone and tissue graft procedures, crown lengthening Perio Splints, Distal Wedge Procedures) are not covered benefits under the plan. Please check with Patient Accounts prior to your appointment regarding fees due.

Prosthodontics (removable complete and partial dentures and bridges).

Most Prosthodontic procedures including repairs and relines have a lab fee due in addition to the member co-pay.

- Initial insertion of partial or complete removable dentures (including any adjustments)
- Replacement or modification (i.e., addition of teeth) of existing fixed bridges or dentures (full or partial). Replacement of prosthodontic appliances shall be covered hereunder only if at least five (5) years have elapsed since the date of the initial insertion of that appliance.

***Denture rebase procedures** for complete and partial dentures is not a covered benefit under the plan.

***Certain precision attachments** are not covered under the plan. Fixed partial Denture Retainers-Inlays/Onlays are not covered under the plan.

***Certain Fixed Partial Denture Retainers** have a fixed benefit amount or a laboratory fee due. Check with Patient Accounts prior to your appointment regarding fees due for these services.

Orthodontics* (subject to deductible)

- Orthodontic diagnostic procedures and treatment including surgical and appliance therapy
- Each participant is entitled to one complete course or orthodontic treatment while you have coverage under this Plan. The patient pays half (50%) the cost, up to a maximum deductible of

$2,500 per participant. If, at the participant's request, the orthodontic treatment is ended before completion, benefit payments will end with the day of termination of treatments. If dental services are resumed a new deductible must be met. If, at the orthodontist's suggestion due to growth issues, the treatment is ended and later resumed, the remaining orthodontic benefits will resume. There is no age limit on orthodontic services.

Laboratory Charges

Patients are responsible for ALL laboratory charges. Laboratory charges are defined to be those actual costs for making or repairing any prosthetic device (such as bridges, dentures or crowns). All laboratory fees must be paid in full by the time the appliance is received. Patients should check with the Patient Accounts staff at the Dental Clinic of Marshfield, S.C. regarding lab fees due. Patients can also request an estimate prior to any work done requiring laboratory charges.

Example:

A participant must have a denture made. All primary fittings and adjustments are done by the dentist in the office. The final processing of the denture is done by a dental laboratory. The participant pays for the laboratory charges (material and labor) for constructing the denture plus the amount not covered by the plan. Payment is due in full by the time the denture is inserted. Down payments can be made prior to the insert appointment.

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DENTAL COM INSURANCE PLAN, INC.

SUMMARY PLAN DESCRIPTION
ADDITIONAL INFORMATION

Your employer (the "Group") has adopted the Dental Com Insurance Plan, Inc. Group Policy No. DCIP-GP-05(5) (the "Plan"). The Plan is an insurance policy issued by Dental Com Insurance Plan, Inc. ("Dental Com").

Detailed and complex legal documents recite the formal text of the Plan. The Member Handbook, Plan Benefit Summary and this additional information comprise the Summary Plan Description (the "SPD") for the Plan. The SPD explains the main provisions of the Plan so that You may understand the Plan's operation and its benefit. The SPD cannot change, add to, or subtract from, the formal Plan document (called the "Group Policy" or "Policy" as referenced above). If the SPD and the Plan document are inconsistent, the formal Plan document will control. The Group reserves the right to amend or terminate the Plan at any time and without prior notice. You may inspect a copy of the Plan document at the Group office.

We suggest that You read the SPD carefully. If You have any questions after reading the SPD, please contact Dental Com at 306 West McMillan Street, P.O. Box 929, Marshfield, WI 54449-0929 or contact your Human Resources, Benefits Manager.

ELIGIBILITY FOR BENEFITS

You are eligible for coverage under the Dental Com Dental Care Plan on the first day of the calendar month following your date of hire provided you are scheduled to work a minimum of 20 hours per week and in a benefit eligible status. You have 31 days following your date of hire in which you can enroll in this Plan. If you choose not to enroll in the Plan during this time period, you will NOT have another opportunity to enroll until the next open enrollment period. However, if the reason you choose not to enroll yourself and/or your dependents is because of coverage under another dental plan and you and/or your dependents subsequently lose eligibility under the other dental plan, you will have 31 days from the date of loss of eligibility under the other dental plan to enroll yourself and/or your eligible dependents in the Plan provided proof of such loss of eligibility is given.

Family Dependents (including your lawful spouse and eligible dependent children) as described in the Member Handbook are also eligible for coverage under the Plan. Benefits for dependents who cease to be participants stop at the end of the

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If an employee is required by a "qualified medical child support order," as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide dental coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

If the employee is not already enrolled, the employee may also enroll as a timely enrollee at the same time.

When the Plan Administrator receives an order by a court or other authorized state agency for an employee to provide coverage for his or her child(ren), the Plan Administrator will review the order to determine whether it is a "qualified medical child support order," entitled to enforcement by the Plan. The Plan's procedures for reviewing these orders is available, without charge, upon written request to the Plan Administrator.

EFFECT OF MEDICAID

As required by federal law:

- This Plan will not take into account the fact that You and/or Your dependent(s) are eligible for or are provided medical assistance by Medicaid, for purposes of determining eligibility or benefits under this Plan.
- In payment of its benefits, this Plan will honor any Medicaid assignment of rights made by or on behalf of You and/or Your dependent(s).
- This Plan will honor any reimbursement or subrogation rights that a state may have by virtue of payment of Medicaid benefits for expenses covered by this Plan.

USERRA

All provisions under the Plan are intended to be in compliance with the Uniformed Service Employment and Reemployment Rights Act of 1994 ("USERRA"). USERRA provides that employees who leave employment for service in the uniformed service (as defined by USERRA) are entitled to continue certain health benefits under the Plan for themselves and their dependents. You should contact the Plan Administrator concerning any of Your rights and/or obligations under USERRA.

FAMILY AND MEDICAL LEAVE ACT

All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Group, Plan benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, obligations of the Group and the employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An employee with questions concerning any rights and/or obligations should contact the Group.

STATEMENT OF ERISA RIGHTS

Plan participants are entitled to certain rights and protections pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Group and Plan Administrator intend to comply fully with ERISA. If You have a question about the Plan, how it is run and how it affects You, You should contact the Plan Administrator or DENTAL COM.

ERISA provides that all Plan participants shall be entitled to:

1. 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 Policies, 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 Policies, and copies of the latest annual report (Form 5500 Series) and updated SPD. 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 participant with a copy of this summary annual report.

2. Continue Group Dental Plan Coverage

Continue dental 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 this SPD and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

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

4. Enforce Your Rights

If Your claim for a 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 administrator. If You have a claim for Benefits that 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.

5. Assistance with Your Questions

If You have any questions about Your 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.

PLAN INFORMATION

Plan Name:

Dental Com Plan

Type of Plan:

The Plan is an employee welfare benefit plan providing dental benefits.

Group, Plan Sponsor and Plan Administrator:

Marshfield Clinic Health System Inc., Family Health Center Inc., Lakeview Medical Center Inc., and Marshfield Clinic Inc.
1000 North Oak Avenue
Marshfield WI 54449
715-387-5341

Insurer:

Dental Com Insurance Plan, Inc.
306 West McMillan Street
P.O. Box 929
Marshfield, WI 54449-0929
(800) 715-387-1702

Agent for Service of Legal Process:

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. If the dispute involves a claim for benefits under the Group Policy, additional service of legal process must be made upon the Insurer at the above address or upon the supervisory official of the Office of the Commissioner of Insurance in the State of Wisconsin.

Plan Year:

A Plan Year is the 12-month period beginning April 1 and ending March 31. All records that relate to the Plan are maintained on a Plan Year basis.

Employer and Plan Numbers:

511. Your Group's EIN is 46-1495343.

Plan Administration:

The Group is the named fiduciary of the Plan and also is the Plan Administrator with the authority to control and manage the operation and administration of the Plan. The Plan Administrator will have the full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following authority, in addition to all other powers provided by this Plan.

(1) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
(2) To appoint such agents, counsel, accountants, consultants, insurers and other persons as may be required to assist in administering the Plan; and
(3) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation or designation to be in writing.

The Plan Administrator's responsibilities include, but will not be limited to:
(1) Maintaining Plan documents at its office,
(2) Responding to requests for information,
(3) Providing COBRA notices (if required), and
(4) All reporting and disclosure required by the U.S. Department of Labor and the Internal Revenue Service.

The Insurer's responsibilities include:
(1) Determining whether an individual is eligible to participate in the Plan,
(2) Reviewing each claim for Benefits to determine whether a particular service is eligible for coverage under the Plan, and
(3) Reviewing claim appeals (Grievances).

In carrying out their respective responsibilities under the Plan, the Plan Administrator, Insurer and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Group will indemnify the Plan Administrator and any employee of the Group serving as Plan Administrator against all liabilities arising by reason of any act or failure to act unless such act or failure to act is due to such person's own negligence, willful misconduct or lack of good faith in the performance of his or her duties under the Plan.

Sources of Contributions and Funding:

Both the Group and employees may make contributions toward the premium cost. The Employer contribution is subject to change each year. You are also required to pay a portion of the cost for some dental services.

Plan Amendment and Termination: While the Group intends to continue this Plan indefinitely, it reserves the right, through action by its President to modify, suspend or terminate this Plan at any time. The Group adopts all provisions of the Group Policy issued by the Insurer as amended from time to time, as part of this Plan.

Summary of Material Modifications (Changes)

Effective April 1, 2017: New plan year cycle begins. Premium increased 2%. No plan design changes.

Effective January 1, 2017: Plan year change from January 1 to April 1. The transition period is January 1, 2017 – March 31, 2017.

Effective January 1, 2016: No premium increase or plan design changes.

Effective January 1, 2015: No premium increase. Application of sealants is limited to the occlusal surface of permanent molars which are free of caries.

Effective January 1, 2014: No premium increase or plan design changes.

Effective January 1, 2013: Premium increased 2%. Patient responsibility for orthodontia increased from $2000 to $2500. Reimbursement for emergency care at a dental facility outside of the service area increased from $50 to $100.

Effective January 1, 2012: Premium increased 2.5%. No plan design changes. Dependent definition changed as a result of WI Budget Bill (Act 32).

Effective January 1, 2011: Premium increased 3.8%. Dependent definition changed as a result of Health Care Reform.

Effective January 1, 2010: Premium increased 4%. Plan design change involves sealants and definition of an eligible dependent, per WI Act 28. Replacement sealants will be covered until the age of 18. Replacement of sealants shall be covered hereunder only if at least (3) years have elapsed since the date of last placement.

Effective January 1, 2009: As announced during re-enrollment season, the premium has increased 4%. There are no plan design changes for 2009. Participants are reminded, when receiving services which require a co-pay or lab fee at the Dental Clinic, those fees must be paid in full on the date services are received. This plan provision allows participants to receive a lower priced, higher benefit, dental plan. Last minute change includes amending the schedule for routine oral examinations and prophylaxis (cleaning of teeth) from once every 6 months to twice every 12 months per covered individual.

Effective January 1, 2008: The premium has increased 4%. There are no plan design changes for 2008. Participants are reminded, when receiving services which require a co-pay or lab fee at the Dental Clinic, those fees must be paid in full on the date services are received. This plan provision allows participants to receive a lower priced, higher benefit, dental plan.

Effective January 1, 2007: The premium has increased 5%. Participants will see a modest increase as a result of the Clinic picking up it's current percentage of the total premium. There are no plan design changes for 2007. Participants are reminded, when receiving services which require a co-pay or lab fee at the Dental Clinic, those fees must be paid in full on the date services are received. This plan provision allows participants to receive a lower priced, higher benefit, dental plan.

Effective January 1, 2006: No plan design changes.