Summary Plan Description

Delta Dental PPO

for

MARSHFIELD CLINIC

HEALTH SYSTEM, INC.

90687

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I. Plan Description Information

1. **Plan Name:** Marshfield Clinic Health System Group Dental Plan

2. **Plan Sponsor:** Marshfield Clinic Health System, Inc
1000 North Oak Avenue
Marshfield, WI 54449

3. **Plan Administrator and Named Fiduciary:**

Marshfield Clinic Health System, Inc. (MCHS)
1000 North Oak Avenue
Marshfield, WI 54449
715-387-5004

4. **Plan Sponsor's Employer Identification Number (EIN):** MCHS 49-1495343
Plan Number: 510

5. The Plan provides dental benefits for participating employees 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 April 1, 2018.

7. The Plan year is April 1 through March 31.

8. **Agent for service of legal process:**

Marshfield Clinic Health System, Inc.
1000 North Oak Avenue
Marshfield, WI 54449
715-387-5004

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.

11. Each employee who participates in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are in 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.

Illegality of Particular Provision:
The illegality of any particular provision of this Plan shall not affect any other provision, but the Plan shall be construed in all respects as if such invalid provision were omitted.

Governing Law:
To the extent not preempted by federal law, this Plan shall be interpreted and applied in accordance with the laws of the state of Wisconsin, as amended from time to time.

II. Description of Benefits

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

Delta Dental PPO Dentists

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

Dentists Outside the Delta Dental PPO Network

Delta Dental Premier Dentists

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

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

Noncontracted Dentists

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

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

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

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.

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, implants, 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.

Summary of Benefits

Group Number: 90687

Effective Date of Program: April 1, 2018

Dependents to Age: 26
Dependents are covered through the end of the calendar month the age limit is reached.

Deductibles:

Per Person, per Benefit Accumulation Period:	$ 40.00
Per Family, per Benefit Accumulation Period:	$120.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period:	$1,500.00
Orthodontic Maximum Benefit: Per Person, per Lifetime:	$2,000.00

Benefits:	**Delta Dental PPO**	**All Other Dentists**
Diagnostic and Preventive Procedures	**100%**	**100%**
Basic Restorative Procedures	**80%***	**80%***
Major Restorative Procedures	**80%***	**80%***
Orthodontic Procedures	**80%***	**80%***

Orthodontics is a covered benefit for you, your spouse and your dependent children to age 26.

Late Enrollee Limitation
Coverage for Basic Restorative, Major Restorative and Orthodontic Procedures are subject to 12 month waiting period if you or your dependents are considered Late Enrollees.

* *Deductible applies.*

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. Plan year is April 1 through March 31.

Covered Procedures

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

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

Evidence-Based Integrated Care Plan ("EBICP") Benefits are provided under your Plan. 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. This Amendment supersedes any previous amendment provided to regarding EBICP.

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 of the Summary Plan Description.

Diabetes

1. With an indicator of a **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 of the 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 of the Summary Plan Description.

Diagnostic and Preventive Procedures

1. Examinations twice in a benefit year.
2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays at twelve month intervals, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) twice in a benefit year.
5. Topical fluoride applications twice in a benefit 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. Application is limited to the occlusal surface of molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.

Basic Restorative Procedures

1. Emergency treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
3. *a*. Amalgam (silver) restorations — 1 placement per tooth surface in a 1-year period;
   b. composite (tooth-colored) restorations in anterior (front) teeth — 1 per tooth surface in a 1-year period;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.

4. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
5. Endodontics (root canal treatment and root canal fillings) —1 per tooth in a 2-year period.
6. 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 in a benefit year.

Major Restorative Procedures

1. Crowns, inlays or onlays, when teeth are broken down by decay or accidental injury and may no longer be restored adequately with a filling.
2. Prosthetics (fixed bridgework, partial or complete dentures, or implants are provided 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);
   a. repairs and adjustments to prosthetic appliances;
   b. denture reline and rebase once in any 3-year period;
   c. porcelain veneers on crowns or pontics on the 6 front teeth, bicuspids and upper first molars;
   d. 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;
   e. fixed bridges and partial or complete dentures where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when needed to replace missing teeth. Fixed bridges are a benefit only if the use of a removable prosthetic appliance is inadequate.

Orthodontic Procedures

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 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. Treatment rendered outside of the United States or Canada.
13. Replacement of lost or stolen dentures or charges for duplicate dentures.
14. 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:

(1) *No Coordination of Benefits Provision*. When your other group coverage does not have coordination of benefits, then that coverage pays first. The Plan pays the balance owed for your covered services.

(2) *Employee/Participant/Participant vs. Dependent*. The benefits of a plan which covers the person for whom claim is made other than as a Dependent will be determined before a plan which covers that person as a Dependent.

(3) *Children of Parents Not Separated or Divorced*. The benefits of a plan which covers the person for whom claim is made as a Dependent of a person whose day of birth occurs first in a calendar year will be determined before a plan which covers that person as a Dependent of a person whose day of birth occurs later in that year; except that: (a) if the other plan does not have this rule, its alternate rule will govern; and (b) in the case of a Dependent child of divorced or separated parents, the rules in item (4) will apply.

(4) *Children of Separated or Divorced Parents*. If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the plan which covers the child as a Dependent of the parent so responsible will be determined before any other plan; otherwise:

(a) The benefits of a plan which covers the child as a Dependent of the parent with custody will be determined before a plan which covers the child as a Dependent of a stepparent or a parent without custody.

(b) The benefits of a plan which covers the child as a Dependent of a stepparent will be determined before a plan which covers the child as a Dependent of the parent without custody.

(5) *Active/Inactive*. The benefits of a plan which covers the person as a laid-off or retired Employee, or his Dependent will be determined after a plan which covers the person as an Employee, other than a laid-off or retired Employee, or his Dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, then this rule will not apply.

(6) *Continuation Coverage*. If a person has continuation coverage under one plan due to federal law (COBRA) or state law, and is also covered under another plan, then the following shall determine the order of benefits:

(a) First, the benefits covering the person as an Employee, Participant or Participant, or a Dependent of an Employee, Participant or Participant.

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

(c) If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, then this rule will not apply.

(7) *Longer/Shorter*. When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a plan which has covered the person for the shorter period of time.

Effect of Medicaid on the Plan:

As required by federal law:

(1) 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.

(2) In payment of its benefits, this Plan will honor any Medicaid assignment of rights made by or on behalf of you and/or your covered Dependent(s).

(3) 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.

Eligibility

Covered Employees:

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

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

Spouse:

A lawful spouse is a person of the opposite sex who is a husband or wife through a legal union (marriage) between one man and one woman (as defined in the 1996 Defense of Marriage Act).

Child(ren):

1. Your children, including step and adopted children and children placed for adoption with you, who are less than 26 years of age.
2. In addition, a child who meets the criteria above and is a full-time student has an extension past age 26 IF the child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was under 27 years of age and attending, on a full-time basis, an institution of higher learning.
3. An unmarried nature child (grandchild) of a dependent child (as described above) until the dependent child is 18 years of age (health insurance only).

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

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

Effective Dates of Coverage:

You are covered by this dental plan beginning on the first day this dental plan becomes effective or the first of the month following benefit eligibility date. Enrollment form must be completed listing all eligible family members to be covered and submitted to Human Resources within 31 days from eligibility date.

Changes in Coverage:

You have special enrollment rights in the Plan when you lose other dental coverage or when you acquire new Dependents. If you marry and wish to change from an individual to a family plan, you must complete a new application (available from the Human Resources office). Family coverage becomes effective on the date of marriage provided your application is made within 31 days of that date as described below. You are required to report any births, adoptions, marriages, divorces (including legal separations) or deaths within 31 days of the event to Human Resources.

Persons Who Lose Other Coverage:

If you refused coverage for yourself or your Dependents during your initial eligibility period, you will be allowed to enroll yourself and your Dependents for coverage as timely enrollees <u>if all of the following conditions are met</u>:

- the other coverage was terminated because of loss of eligibility (including legal separation, divorce, death, termination of employment, reduction in the number of

hours of employment), termination of the employer's contribution toward such coverage, or exhaustion of the individual's coverage under COBRA; and

- you request enrollment in the Plan no later than 31 days after losing coverage as a result of loss of eligibility, COBRA exhaustion, or the termination of the employer's contributions.

If you enroll on a timely basis, the effective date of coverage under this Plan will be the first of the month following loss of coverage. If you do not enroll on a timely basis, you will not be able to enroll until the next open enrollment cycle; January 2010, 2015, 2020, etc.

Acquisition of Dependent Beneficiaries:

You can enroll your eligible Dependents as timely enrollees <u>if all of the following conditions are met</u>:

- you are enrolled in the Plan;

- the Plan makes coverage available to Dependents of Employees;

- a spouse or a child becomes your Dependent through marriage, birth, adoption or placement for adoption; and

- you request enrollment for your spouse and/or the child(ren) acquired through the marriage, birth, adoption or placement for adoption within 31 days of the event.

If you enroll on a timely basis, the effective date of coverage under this Plan will be the date of marriage, birth, adoption or placement for adoption. If you do not enroll on a timely basis, you will not be able to enroll your spouse or dependent(s) until the next annual open enrollment.*

During the annual re-enrollment/transfer you will be able to change your election. The election process takes place in March. The effective date will be the following April 1. Allowable changes include:

- switch between one of the other offered dental plans
- cancel coverage
- remove otherwise eligible dependents (spouse or a child)
- enroll or add eligible dependents (spouse or a child).*

***Participants who enroll or add a dependent during the annual enrollment period will be eligible for diagnostic/preventive services only for the first 12 months.**

Qualified Medical Child Support Orders:
If you are required by a "qualified medical child support order," as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for your children, these children can be enrolled as timely enrollees as required by OBRA 93. If you have not already enrolled, you may also enroll as a timely enrollee at the same time.

When you receive an order by a court or other authorized state agency to provide coverage for your child(ren), the Employer 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 to you, without charge, upon written request to the Employer.

A Dependent child will also become covered as of the date specified in a National Medical Support Notice ("NMSN") as provided under ERISA section 609(a).

FMLA:
If you take a leave of absence in accordance with the federal Family and Medical Leave Act ("FMLA") (or any state family and medical leave act, to the extent it requires similar protections), coverage for you and your Dependents will be continued under the same terms and conditions as if you had continued performing services for the Employer, provided you continue to pay your regular contribution towards coverage.

If you fail to make the required contribution for coverage within the 31 day grace period from the contribution due date, then your coverage will terminate as of the end of the month for which the last contribution was paid.

If you do not return to work for the Employer after the approved FMLA Leave or if you have given notice of intent not to return to work during the leave, or if you exhaust your FMLA entitlement, coverage may be continued under the Continuation of Coverage (COBRA) provision as described later in this Summary Plan Description, provided you elect to continue under the COBRA provision. Continuation of Coverage (COBRA) will be provided only if the following conditions have been met:

(1) You were covered under this Plan on the day before the FMLA leave began or became covered during the FMLA leave;

(2) You do not return to work after an approved FMLA leave; and

(3) Without COBRA, you would lose coverage under this Plan.

Continuation of Coverage (COBRA) will become effective on the last day of the month of the FMLA leave as determined below:

(1) The last day of the month during which you fail to return to work after an approved FMLA Leave;

(2) The last day of the month during which you inform the Employer that you do not intend to return to work; or

(3) The last day of the month during which you exhaust your FMLA entitlement and fail to return to work.

Coverage continued during an FMLA Leave will not be counted toward the maximum COBRA continuation period.

If you decline coverage during the FMLA leave period or if you elect to continue coverage during the FMLA leave and fail to pay the required contributions, you will still be eligible for COBRA continuation at the end of the FMLA leave, if you do not return to work. COBRA continuation will become effective on the last day of the FMLA leave. You need not provide evidence of good health to elect COBRA continuation, even if there was a lapse in coverage during the FMLA leave period.

If coverage lapses for any reason during an FMLA leave and you return to work on a timely basis following an approved FMLA leave, coverage will be reinstated as if you had continued performing services during the leave, including Dependent coverage. Reinstatement will be provided without having to satisfy any waiting period, or provide evidence of good health.

Date: 11/01/2016

USERRA :
The following provisions are required under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

Continuation of Coverage Due to Military Leave
If you are absent from work due to a leave for military service and were covered under this plan prior to the leave, coverage for you and your dependents may be continued for a period that is the lesser of eighteen (18) months or a period that ends the day you fail to apply for or return to a position of employment. Coverage continued during the military service will be counted toward the maximum COBRA continuation period. The eighteen (18) month period is measured from the date you leave work for military service.

If you are on military leave for less than thirty-one (31) days, your contribution for coverage will be the same as while you were actively at work. If your military leave extends for more than thirty-one (31) days, then you are required to pay the full cost of coverage. You also have continuation rights under COBRA as also described in this Summary Plan Description.

Reinstatement of Coverage Following Military Leave
If you are reemployed following military leave, you will be covered under the same terms and conditions that would have been provided had you continued actively working.

Your coverage will be reinstated on your date of reemployment, provided the following conditions are met:

(1) You have given advance written or verbal notice of the military leave to the Employer (advance notice to the Employer is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);

(2) The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;

(3) Reemployment follows a release from military service under honorable conditions; and

(4) You report to, or submit an application for reemployment to the Employer as follows:

(a) On the first business day following completion of military service for a leave of thirty (30) days or less; or

(b) With fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or

(c) Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty (180) days.

If you are hospitalized for, or recovering from, an illness or injury when your military leave expires, you have two (2) years to apply for reemployment.

If you provide written notice of intent not to return to work after military leave, You are not entitled to reemployment benefits.

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods or preexisting condition limitation will apply to you or your Dependents. Credit will be given toward the preexisting conditions limitation for any time satisfied under the plan from you or your Dependent's original effective date. However, a waiting period, preexisting condition limitation and/or Plan exclusion may apply for illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service.

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:

Termination of Employee Coverage
Your dental coverage under this Plan will terminate as of the earliest of the following dates:

(1) The date the Plan terminates;

(2) The last day of the month in which you die;

(3) The last day of the month for which you made your final contribution for coverage;

(4) The last day of the month in which your status as an Employee ends as determined by the Employer;

(5) The last day of the month in which you enter into active military service, other than for duty of less than 30 days; or

(6) The last day of the month in which you are not within the class of Employees eligible for coverage under the Plan.

Termination of Dependent Coverage
For a Dependent child, coverage terminates as of the earliest of the following dates:

(1) The date the child marries or becomes covered as an Employee;

(2) The end of the calendar year the child reaches the applicable age for Dependent children (19), if he/she is not a full-time student;

(3) The last day of the calendar month the child no longer attends school as a full-time college/university student.

(4) The last day of the calendar year in which the Dependent student reaches the applicable age for Dependent students (25); or

(5) The last day of the calendar month in which the child ceases to be an eligible Dependent.

For Dependent spouses, coverage terminates on the date that the Employee is no longer married to the spouse due to divorce, legal separation or annulment.

For all Dependents, coverage terminates as of the earliest of the following dates:

(1) The date the Plan terminates;

(2) The date the Employee is no longer covered;

(3) The last day of the month for which the Employee has made a final contribution for Dependent coverage;

(4) The date the Dependent enters active military service;

(5) The last day of the month in which the Employee is no longer eligible for Dependent coverage or Dependent coverage is no longer provided by the Plan;

(6) The last day of the month in which the Dependent ceases to be an eligible Dependent as defined by this Plan, except as otherwise provided for Dependent children above.

(7) The date the Dependent dies.

The Plan Sponsor Employer fully intends to maintain this Plan indefinitely; however, the Employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan.

Federal Continuation Provision (COBRA)

Federal law requires most employers sponsoring group dental plans to offer employees and their families the opportunity to elect a temporary extension of dental coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under the group dental plan would otherwise end. You do not have to show that you are insurable to elect continuation coverage. However, you will have to pay all of the cost of your continuation coverage.

This section is intended only to summarize, as best possible, your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly.

Both you (the Employee) and your spouse should read this summary carefully and keep it with your records.

Qualifying Events

If you are an Employee of the Employer covered by the Plan, you have a right to elect continuation coverage if you lose coverage under the Plan because of any one of the following two "qualifying events":

(1) Termination (for reasons other than your gross misconduct) of your employment.

(2) Reduction in the hours of your employment.

If you are the spouse of an Employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

(1) The death of your spouse.

(2) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with the Company.

(3) Divorce or legal separation from your spouse. (Also, if an Employee drops his or her spouse from coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan within 60 days of divorce and can establish that the coverage was dropped earlier in anticipation of divorce, then COBRA coverage may be available for the period after the divorce or legal separation.)

(4) Your spouse becomes entitled to Medicare benefits.

In the case of a Dependent child of an Employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

(1) The death of the Employee parent.

(2) The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction in the Employee parent's hours of employment with the Employer.

(3) Parents' divorce or legal separation.

(4) The Employee parent becomes entitled to Medicare benefits.

(5) The Dependent ceases to be a "Dependent child" under the Plan.

Notices and Election

The Plan provides that your spouse's coverage terminates (thus, is lost) as of the last day of the month in which a divorce or legal separation occurs. A Dependent child's coverage terminates the last day of the month in which he or she ceases to be an eligible Dependent under the Plan (for example, after attainment of a certain age). Under the COBRA statute, you (the Employee) or a family Member has the responsibility to notify the Plan Administrator upon a divorce, legal separation, or a child losing Dependent status. You or a family Member must provide this notice no later than 60 days after the last day of the month of the divorce, legal separation, or a child losing Dependent status. If you or a family member fail to provide this notice to the Plan Administrator during this 60-day notice period, any family Member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family Member fail to notify the Plan Administrator, and any claims are paid mistakenly for expenses Incurred after the last day of the month of the divorce, legal separation, or a child losing Dependent status, then you and your qualifying family Members will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is provided timely notice of a divorce, legal separation, or a child's losing Dependent status that has caused a loss of coverage, the Plan Administrator will notify the affected family Member of the right to elect continuation coverage.

You (the Employee) and/or your qualifying family Member will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family Member) upon the following events that result in a loss in coverage: the Employee's termination of employment (other than for gross misconduct), reduction in hours, or death, or the Employee becoming entitled to Medicare.

You (the Employee) or your qualifying family Member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Plan Administrator

sends you or your family Member notice of the right to elect continuation coverage. If you or your qualifying family Member do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. Your (or your qualifying family Member's) election is effective on the day the election is sent to the Plan Administrator. Please Note: No claims will be paid until the COBRA payment is received.

A covered Employee or the spouse of the covered Employee may elect continuation coverage for all qualifying family Members. The covered Employee, and his or her spouse and Dependent children each have an independent right to elect continuation coverage. Thus a spouse or Dependent child may elect continuation coverage even if the covered Employee does not (or is not deemed to) elect it.

You or your qualifying family Member can elect continuation coverage if you or the family Member, at the time you or the family Member elect continuation coverage, are covered under another employer-sponsored group health plan or are entitled to Medicare.

Type of Coverage; Payment of Contributions

Ordinarily, you or your qualifying family Member will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, a person (Employee, spouse or Dependent child) who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce.

If the coverage for similarly situated Employees or their family Members is modified, COBRA coverage will be modified the same way.

The premium payments for the "initial premium months" must be paid for you (the Employee) and any qualifying family Member by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the date of the COBRA election. All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is made on the date it is post-marked or actually received; whichever is earlier.

Maximum Coverage Periods

<u>36 Months</u>. If you (spouse or Dependent child) lose group dental coverage because of the Employee's death, divorce, legal separation, or the Employee's becoming entitled to Medicare, or because you lose your status as a Dependent under the Plan, the maximum coverage period (for spouse and Dependent child) is 36 months from the last day of the month in which the qualifying event occurs.

18 Months. If you (Employee, spouse or Dependent child) lose group dental coverage because of the Employee's termination of employment (other than for gross misconduct) or reduction in hours, the maximum continuation coverage period (for the Employee, spouse and Dependent child) is 18 months from the last day of the month in which the termination or reduction in hours occurs. There are three exceptions:

(1) If an Employee or family Member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the last day of the month in which the termination or reduction in hours occurs. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator both within the 18-month coverage period and within 60 days after the date of the determination.

(2) If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, the maximum coverage period becomes 36 months from the last day of the month in which the initial termination or reduction in hours occurs.

(3) If the Employee is entitled to Medicare at the time of an initial qualifying event due to termination or reduction of hours worked, then the period of continuation for other family Members who are qualified beneficiaries is the later of 36 months from the end of the month in which the Employee became entitled to Medicare, or 18 months from the last day of the month in which the termination or reduction in hours occurred. If the Employee becomes entitled to Medicare during the initial continuation period of 18 months following the original qualifying event, other family Members who are qualified beneficiaries will be entitled to continuation of 36 months from the date of the last day of the month in which the original qualifying event occurred.

Children Born To, or Placed for Adoption With the Covered Employee after the Qualifying Event

If, during the period of continuation coverage, a child is born to, adopted by or placed for adoption with the covered Employee and the covered Employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered Employee or a family Member must notify the Plan Administrator within 31 days of the birth, adoption or placement to enroll the child on

COBRA, and COBRA coverage will last as long as it lasts for other family Members of the Employee. (The 31-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption). If the covered Employee or family Member fails to so notify the Plan Administrator in a timely fashion, the covered Employee will NOT be offered the option to elect COBRA coverage for the child.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Employee, spouse and/or Dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

(1) The Employer no longer provides group dental coverage to any of its Employees.

(2) The premium for the qualified beneficiary's COBRA coverage is not timely paid.

(3) After electing COBRA, you (Employee, spouse or Dependent child) become covered under another group dental plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group dental plan. (Note that under Federal law (the Health Insurance Portability and Accountability Act of 1996), an exclusion or limitation of the other group dental plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group dental plan.)

(4) After electing COBRA, you (Employee, spouse or Dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.

(5) If you (Employee, spouse or Dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination).

(6) Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Employees or their spouses or Dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of Federal law.

Other Information

If you (the Employee) or a qualifying family Member have any questions about this notice or COBRA, please contact your Human Resources Department. If your marital status changes, or a Dependent ceases to be a Dependent eligible for coverage under the Plan terms, or your or your spouse's address changes, you must immediately notify the Plan Administrator.

III. Claims Procedures

The following claims procedures are effective January 1, 2003. If the Plan fails to follow the procedures detailed below in accordance with applicable law, you may be entitled to pursue any available remedies under section 502(a) of ERISA.

(1) 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.

(2) Filing Claims

Delta Dental is the Claims Administrator for the Plan. To file a claim with Delta Dental, simply present you ID card to the receptionist at the dental office, or give your Social Security number. Delta Dental accepts any standard claim form and will provide claim forms to your dentist on request.

(3) Questions on Claims Procedures and Denials

If you have questions about filing a claim for benefits or about a 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 (as described below).

(4) Who May File a Claim

You or your Dependent may have someone act on your behalf for purposes of filing claims, making inquiries and filing appeals. If you have an authorized representative, the Plan will direct all claims information and notifications to your authorized representative.

(5) General Rules for Claims Review

The period of time for deciding a claim will begin when a claim is filed in accordance with the claim filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing. If the time period is extended due to your failure to submit information necessary to decide the claim, the time period for processing the claim is suspended from the date on which the notice is sent to you to the date the Plan receives your response to the request. For the purposes of these Claims Procedures, days are measured in calendar days. Additionally, the Plan relies on a general presumption that a notice sent by first class mail will be received within five business days.

(6) Types of Claims

How you file a claim for benefits depends on the type of claim it is. There are several categories of claims for benefits:

Pre-Service Care Claim—A pre-service claim is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval of the benefit in advance of obtaining medical care.

Urgent Care Claim—An urgent care claim is any claim for medical care or treatment with respect to which, in the opinion of the treating physician, lack of immediate processing of the claim could seriously jeopardize the life or health of you or your insured dependent or subject you or your dependent to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This type of claim generally includes those situations commonly treated as emergencies.

Concurrent Care Claim—A concurrent care claim is a claim for an extension of the duration or number of treatments provided through a previously-approved claim. Where possible, this type of claim should be filed at least 24 hours before the expiration of any course of treatment for which an extension is being sought.

Post-Service Care Claim—A post-service claim is a claim for payment or reimbursement after services have been rendered.

(7) Timing of Claims Determinations

Urgent Care Claims. If your claim involves urgent care, you or your authorized representative will be notified of the Plan's initial decision on the claim as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; the Plan then must inform you of its decision within 48 hours of receiving the additional information.

Concurrent Care Claims. If your claim is one involving concurrent care, the Plan will notify you of its decision within 24 hours after receiving the claim, if the claim was for urgent care and was received by the Plan at least 24 hours before the expiration of the previously approved time period for treatment or number of treatments. You will be given time to provide any additional information required to reach a decision. If your concurrent care claim does not involve urgent care or is filed less than 24 hours before the expiration of the previously approved time period for treatment or number of treatments, the Plan will respond according to the type of claim involved (i.e., urgent, pre-service or post-service).

Pre-Service Claims. If your claim is for pre-service authorization, the Plan will notify you of its initial determination as soon as possible, but not more than 15 days from the date it receives the claim. This 15-day period may be extended by the Plan for an additional 15 days if the extension is required due to matters beyond the Plan's control. You will have at least 45 days to provide any additional information requested of you by the Plan.

If you fail to follow the Plan's procedures for filing a pre-service claim, you or your authorized representative shall be notified orally or in writing not later than 5 days (24 hours in the case of urgent care) following the failure. This notice, however, applies only when you submit a claim to the appropriate claims unit with the requested identifying claim information.

Post-Service Claims. If your claim is for a post-service reimbursement or payment of benefits, the Plan will notify you within 30 days of receipt of the claim if the claim has been denied or if further information is required. The 30 days can be extended to 45 if the Plan notifies you within the initial 30 days of the circumstances beyond the Plan's control that require an extension of the time period, and the date by which the Plan expects to render a decision.

If more information is necessary to decide a post-service claim, the Plan will notify you of the specific information necessary to complete the claim. You will be given at least 45 days from the receipt of the notice to provide the necessary information.

(8) Notice of Claims Denial

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 a written or electronic notice of the decision. The decision will be sent on a form entitled "Explanation of Benefit." The written or electronic notice will contain the following information:

(a) The reason(s) why the claim or a portion of it was denied;

(b) Reference to plan provisions on which the denial was based;

(c) If the denial was based in whole or in part on any internal rules, guidelines or protocols, a statement that you may request a copy of the rule, guideline or protocol, which will be provided free of charge;

(d) If the denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided free of charge;

(e) What additional information, if any, is required to perfect the claim and why the information is necessary; and

(f) What steps you may take if you wish to appeal the decision, the time limits applied to such procedures; and that you may file an action in federal court under section 502 of ERISA, if you disagree with the Plan's decision on the appeal.

(9) How and When to File a Claims Appeal

If you dispute a denial of benefits, you may file an appeal within 180 days of receipt of the denial notice. This appeal must be in writing (unless the claim involves urgent care, in which case the appeal may be made orally).

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.

In connection with your right to appeal the initial claims determination, you also:

(a) may review pertinent documents and submit issues and comments in writing;

(b) will be given the opportunity to submit written comments, documents, records, or any other matter relevant to your claim;

(c) will, at your request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits; and

(d) be given a review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, regardless of whether such information was submitted or considered in the initial benefit determination.

The claim review will be subject to the following rules:

(a) The claim will be reviewed by an appropriate named fiduciary of the Plan, who is neither the individual who made the initial denial nor a subordinate of that individual.

(b) The review will be conducted without giving deference to the initial denial.

(c) If the initial denial was based in whole or in part on a medical judgment (including any determinations of Medical Necessity or Experimental/Investigative treatment), the reviewer will consult with a dental care professional who has appropriate training and experience in the field of dentistry involved in the medical judgment. This dental care professional shall not be an individual who was consulted on the initial claim denial nor the subordinate of such an individual. Upon request, the Plan will identify by name any medical or vocational experts consulted in the review process.

(d) The review will consider all information submitted, regardless of whether it was considered during the initial determination.

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. Delta Dental will provide you with written notice of the meeting place and time at least 7 days before the meeting.

(10) Timetable for Deciding Appeals

The Plan must issue a decision on your appeal according to the following timetable:

Urgent Care Claims—not later than 72 hours after receiving your request for a review.

Pre-Service Claims—not later than 30 days after receiving your request for a review.

Post-Service Claims—not later than 60 days after receiving your request for a review.

Decisions will be issued on concurrent claim appeals within the time-frame appropriate for the type of concurrent care claim (i.e., urgent, pre-service or post-service).

(11) Notice of Decision on Appeal

If the appeal has been either partially or completely denied, you will be provided with a written notice containing the following information:

(a) The specific reasons for the appeal denial;

(b) Reference to the specific plan provisions on which the denial is based;

(c) A statement that you may request reasonable access to and copies of all documents, records and other information relevant to your appealed claim for benefits, which shall be provided to you without charge;

(d) A description of any voluntary appeal procedures, if any.

(e) If the appeal denial was based in whole or in part on any internal guidelines or protocols, a statement that you may request a copy of the guideline or protocol, which will be provided to you without charge;

(f) If the appeal denial was based in whole or in part on Medical Necessity, Experimental/Investigative treatment or a similar limit or exclusion, a statement that you may request the scientific or clinical judgment for the determination which applies the terms of the plan to the patient's medical circumstances, which will be provided to you without charge; and

(g) A statement regarding your right to bring an action under section 502(a) of ERISA.

These review procedures shall be the exclusive mechanism through which determinations of eligibility and benefits may be appealed. The determination rendered on appeal shall be binding on all parties.

(12) Legal Action

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 the Plan's claim appeal procedures. Also, no legal action can be brought against Delta Dental or Marshfield Clinic more than 3 years after the date of the Plan's final decision on the review of the benefits determination.

Subrogation and Reimbursement:

The Plan shall be subrogated to the extent of any payments made or to be made by the Plan, on account of a claim to all rights of recovery of you or your Dependent, against any person, organization or other entity in connection with the Illness, accident or condition to which the claim relates. The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to any payments or proceeds, or to reimbursement from such payments or proceeds, resulting from any settlement or judgment by you or your dependent against any person, organization or other entity in connection with the Illness, accident or condition to which the claim relates, including the employer under the provisions of a Worker's Compensation or Occupational Disease Law. Such subrogation and reimbursement rights will apply on a priority, first dollar basis to any recovery whether by suit, settlement or otherwise, whether a partial or full recovery and regardless of whether you or your

Dependent is made whole and shall apply to any and all amounts of recovery regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

The Plan shall have no right of subrogation or reimbursement against an insurance carrier arising out of an individual policy of insurance maintained by you or your dependent, except policies which provide "no-fault" automobile insurance.

(1) Action Required of an Employee

If requested in writing by the Plan Administrator, you or your Dependent shall take such action as may be necessary or appropriate to recover payments made by the Plan from any person, organization, or other entity, and you or your Dependent shall hold any money recovered from such person, organization or other entity in trust for the benefit of the Plan to be paid to the Plan immediately upon recovery of the amounts. Neither you nor your Dependent shall do anything to impair, release, discharge or prejudice the rights referred to in this section. You and/or your Dependent shall assist and cooperate with representatives designated by the Plan to recover amounts paid by the Plan and shall do everything that may be necessary to enable the Plan to exercise its subrogation and reimbursement rights described herein.

The Plan Administrator may also require you or your dependent to execute a subrogation and reimbursement agreement, in a form acceptable to the Plan Administrator, as a condition to receiving benefits for a claim.

(2) Enforcement of Rights

The Plan has the right to receive amounts representing the Plan's subrogation and reimbursement interests under this section 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, 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. The Plan's subrogation and reimbursement interests, and rights to legal or equitable relief, take priority over the interest of any other person or entity.

Further, in the event you or your Dependent receives monies as a result of an illness, accident or condition, and the Plan is entitled to such monies in accordance with this section and is not reimbursed the amount it has paid for such illness, accident or condition, the Plan shall have the right to reduce future payments due to you or your Dependent(s), by the amount of the benefits paid by the Plan. The right of offset shall not, however, limit the rights of the Plan to recover such over-payments in any other manner.

IV. Statement of ERISA Rights

As a Participant in the Plan, You are entitled to certain rights and protections under ERISA. ERISA provides that all plan Participants 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 worksites, 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 Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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.

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 summary plan description and the documents governing the plan on the rules governing Your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA 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 welfare benefit or exercising Your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive

the materials, unless the materials were not sent because of reasons beyond the control of the 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 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 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

V. Privacy Statement

Privacy Rights Under the Health Insurance Portability and Accountability Act of 1994 ("HIPAA"):
The Plan protects the privacy of your medical information. The Plan will use and disclose Protected Health Information ("PHI") in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the "Privacy Regulations"). The following provisions address disclosures of PHI to the Plan Sponsor, Marshfield Clinic, for Plan administration purposes. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

(1) ***Disclosure of PHI***

(a) Disclosures by Plan. The Plan may disclose PHI to the following employees or classes of employees of the Plan Sponsor ("Authorized Employees") to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations: Benefits Manager and/or Human Resources (Benefits) Assistants.

(b) Disclosures by Business Associates. The Plan's Business Associates may disclose PHI to the Authorized Employees of the Plan Sponsor to the extent necessary for the Plan Sponsor to perform Plan administration functions that qualify as Payment or Health Care Operations.

(c) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Authorized Employees of the Plan Sponsor to the extent necessary for the Plan Sponsor to perform the following Plan administration functions:

(i) the Plan's Payment activities,
(ii) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and
(iii) all of the Plan's Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

(2) ***Uses and Disclosures of PHI by the Plan Sponsor.***
The Authorized Employees of the Plan Sponsor shall use and/or disclose PHI only to the extent necessary to perform Plan administration functions that qualify as

Payment or Health Care Operations, or as otherwise permitted or required by the Privacy Regulations.

(3) ***Privacy Safeguards.***
The Authorized Employees of the Plan Sponsor agree to:

(a) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(b) Ensure that any subcontractors or agents to whom the Plan Sponsor provide PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(d) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

(e) Report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for in the Plan;

(f) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(h) Make available the information required to provide an accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;

(j) If feasible, return or destroy all PHI that the Plan Sponsor maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Plan Sponsor. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or

destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and

(k) Ensure that adequate separation between the Plan and the Plan Sponsor is established, as described below.

(4) Adequate Separation. In accordance with HIPAA, only the Authorized Employees may be given access to PHI, and such information will be used only for Plan administration activities, not for employment-related activities.

(5) Limitations of PHI Access and Disclosure. The Authorized Employees may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan as described above.

(6) Noncompliance Issues. If the Authorized Employees do not comply with these privacy requirements, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

VI Summary of Material Modifications (Changes)

Effective April 1, 2018: Introduced Employee+1 coverage type. Premiums adjusted as a result. No plan design changes.

Effective April 1, 2017: New plan year cycle begins. No premium increase. No plan design changes. Allowed annual open enrollment with 12 month benefit limitation.

Effective January 1, 2017: Plan year change from January 1 to April 1. The transition period is January 1, 2017 – March 31, 2017. Premium increase 4%.

Effective January 1, 2016: No plan design changes. Premium increased 1.7%.

Effective January 1, 2015: Addition of enhanced dental benefits. Premium decrease of 1.7%.

Effective January 1, 2014: No plan design changes. Premium increase 0%.

Effective January 1, 2013: No plan design changes. Premium increased 2.9%.

Effective January 1, 2012: No plan design changes. Premium increased 2.7%. Dependent definition changed as a result of WI Budget Bill (Act 32).

Effective January 1, 2011: No plan design changes. The premium increased 0%. Dependent definition changed as a result of Health Care Reform.

Effective January 1, 2010: Delta Dental will cover sealants for eligible dependents through age 18. Coverage for bitewing x-rays will be one time per 12-month period and full-mouth x-rays once every 5 years. The premium increased 9.8%. Dependent definition changed as a result of WI Act 28.

Effective January 1, 2009: Delta Dental will be offering a passive PPO. This means when you see a Delta Dental PPO provider you will be charged a fee lower than either a Delta Dental Premier or a Non-Participating Provider.

Please see the Delta Dental PPO summary for more information on savings. You can find a participating provider at www.deltadentalwi.com. The premium has increased 1.5%.

Effective January 1, 2008: The benefit modification includes an increase in the per person annual maximum benefit. Effective January 1, 2008 the benefit increased from $1100 to $1500. Again, this is a per person per plan/calendar year benefit. The premium has increased 4.5%.

Effective January 1, 2007: Participants will see a modest premium increase as a result of the Clinic picking up it's current percentage of the total premium. The premium has increased less than 1%. The benefit modification includes benefit dollars approved for prosthetics may be applied towards implant related procedures. See Covered Procedures, Major Restorative Procedures, Prosthetics section of this Summary Plan Description. Note: If considering an implant, be sure to ask your dentist to submit a treatment plan to Delta Dental for a Predetermination for Benefits form

Effective January 1, 2006: The per person annual maximum benefit increased from $1000 to $1100.