Summary Plan Description

Delta Dental PPO

for

BELLIN GUNDERSEN HEALTH SYSTEM, INC.

50515

Enhanced

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II. Plan Description Information

Bellin Gundersen Health System, Inc. is the employer and plan sponsor and is responsible for payment of claims for its employees and their dependents.

1. Plan Name ("Plan"): Bellin Gundersen Health System, Inc. Health and Welfare Benefits Plan

2. Plan Sponsor: Bellin Gundersen Health System, Inc.
   1836 South Ave
   La Crosse, WI 54601

3. Plan Administrator and Named Fiduciary:

   Bellin Gundersen Health System, Inc.
   1836 South Ave
   La Crosse, WI 54601
   608-782-7300

4. Plan Sponsor's Employer Identification Number (EIN): 92-0504278.
   The Plan number assigned for government reporting purposes is 512.

5. The Plan provides dental benefits for participating employees, certain retirees [if applicable], and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.

6. Plan benefits described in this booklet are effective January 1, 2025.

7. The Plan year and fiscal year are January 1 – December 31.

8. Agent for service of legal process:
   Benefits Manager
   Bellin Gundersen Health System, Inc.
   1836 South Ave
   La Crosse, WI 54601

9. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan has full and final authority on all claim denial disputes. The Claims Administrator is:
   Delta Dental of Wisconsin
   P.O. Box 828
   Stevens Point, WI 54481
   Telephone: 715-344-6087
   Toll Free: 800-236-3712

10. The Plan's contributions are shared by the employer and employee. The employer contribution is subject to change each year, depending upon claims experience and Plan expenses. The employer will pay a portion of the total annual premium for employees. Retirees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.

11. Each employee participating in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are this booklet. This booklet will be provided by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to covered persons as required by applicable law.

13. Upon termination of the Plan, the rights of the covered persons to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for the exclusive benefit of the covered persons, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the employer and any covered person and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

III. 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 provider you choose on a treatment-by-treatment basis whether or not the provider is included in our Delta Dental PPO Provider Directory. It is important to remember, however, that your out-of-pocket costs may be lower when you see a Delta Dental PPO provider.

Delta Dental PPO Providers

Delta Dental PPO Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, 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 providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Providers Outside the Delta Dental PPO Network

Delta Dental Premier Providers

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

Noncontracted Providers

If your provider has not signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the provider. You will then reimburse your provider 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 provider is not allowed in full, Delta Dental is not implying that the provider is overcharging. Dental fees vary and are based on each provider's overhead, skill, and experience. Therefore, not every provider will have fees that fall within the MPA.

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

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit.

Filing Claims

To file a claim with Delta Dental, simply present your employee identification card to the receptionist at the dental office, or give your member number. Claims must be filed on forms acceptable to Delta Dental.

Predetermination of Benefits

After an evaluation, your provider may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or implants, ask your provider to send the treatment plan with x-rays 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 provider.

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 provider the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Optional Procedures

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive dental procedure that is adequate to restore the tooth or dental arch to contour and function, but only if the more expensive dental procedure is a benefit under your dental Plan. You will be responsible for the remainder of the provider's fee if a more expensive dental procedure is selected or the entire fee if the more expensive dental procedure is not a benefit. The coinsurance and deductible will apply regardless of which dental procedure is selected.

Clerical or Administrative Error

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

Summary of Benefits

Group Number: 50515

Effective Date of Program: January 1, 2025

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

Deductibles:	**Delta Dental PPO**	**Delta Dental Premier**	**All Other Dentists**
Per Person, per Benefit Accumulation Period:	$0.00	$ 50.00	$ 75.00
Per Family, per Benefit Accumulation Period:	$0.00	$ 150.00	$225.00
Benefit Maximums:			
Per Person, per Benefit Accumulation Period:	$2,000.00 **	$2,000.00 **	$2,000.00 **
Orthodontic Maximum Benefit per Lifetime Per Employee, Spouse, Dependent Child to age 26:	$2,000.00	$2,000.00	$1,500.00

**There is no annual Benefit Maximum applied to Diagnostic and Preventive Procedures.

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

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

Benefits:	**Delta Dental PPO**	**Delta Dental Premier**	**All Other Dentists**
Diagnostic and Preventive Procedures I	**100%**	**100%**	**100%**
Diagnostic and Preventive Procedures II	**100%**	**100%**	**70%**
Basic Restorative Procedures	**80%**	**70%***	**70%***
Major Restorative Procedures	**80%**	**70%***	**70%***
Orthodontic Procedures	**50%**	**50%**	**50%**

** 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. The Benefit Accumulation Period is January 1 through December 31.

Covered Procedures

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

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

Evidence-Based Integrated Care Plan (EBICP)

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

The EBICP benefits are as follows:

Periodontal Disease

1. With an indicator of surgical or nonsurgical 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 nonsurgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Diabetes

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

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

With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:

- History of infective endocarditis
- Certain congenital heart defects (such as having one ventricle instead of the normal two)
- Individuals with artificial heart valves
- Heart valve defects caused by acquired conditions like rheumatic heart disease
- Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
- Individuals with pulmonary shunts or conduits
- Mitral valve prolapse with regurgitation (blood leakage)

Suppressed Immune System Conditions

1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Kidney Failure or Dialysis Conditions

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

Cancer Related Chemotherapy and/or Radiation

1. With an indicator for **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Diagnostic and Preventive Procedures I

1. Evaluations two times per Benefit Accumulation Period.
2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals. Full mouth x-rays may be either individual images or panoramic image.
3. Bitewing x-rays one time per Benefit Accumulation Period, limited to a set of 4 images.
4. Prophylaxis (teeth cleaning) two times per Benefit Accumulation Period.
5. Topical fluoride applications two times per Benefit Accumulation Period, for dependent children up to age 19.
6. Topical application of sealants for dependents up to age 19.

Diagnostic and Preventive Procedures II

1. Space maintainers for retaining space when a posterior primary tooth is prematurely lost.

Basic Restorative Procedures

1. Emergency treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
3. *a*. amalgam (silver) restorations;
   b. composite (tooth colored) restorations on all teeth;
   c. prefabricated crowns — 1 per tooth at 3-year intervals.
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).
6. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical benefit is limited to once per quadrant at 24-month intervals; surgical benefit is limited to once per quadrant at 36-month intervals. Periodontal maintenance — either periodontal maintenance or adult prophylaxis two times per Benefit Accumulation Period.

Major Restorative Procedures

1. Crowns, inlays or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material.
2. Prosthetics, including fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth. Coverage for the purpose of replacing defective existing full and partial dentures will be provided only after a five-year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure under this dental Plan.
   Fixed bridges, implants, or partial/complete dentures are provided where chewing function is impaired due to missing teeth.
   a. repairs and adjustments to prosthetic appliances;
   b. denture reline or rebase is a benefit at three-year intervals;
   c. porcelain veneers on crowns or pontics on all teeth.

   Coverage for initial replacement of teeth is not limited to those lost while you are covered under this dental Plan.

Orthodontic Procedures

Orthodontic services include orthodontic appliances, treatment, and related services for orthodontic purposes, including evaluation, x-rays, 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 Dental will determine the unearned amount eligible for coverage.

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, subject to the coverage percentage, any applicable deductible and the orthodontic maximum benefit stated herein. 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. Dental procedures, services treatment or supplies provided or commenced prior to the effective date of your coverage under this dental Plan or after the termination date of coverage, unless otherwise indicated;
2. Dental procedures, services treatment or supplies to treat injuries or conditions compensable under worker's compensation or employer's liability laws;
3. Prescription drugs, premedications or relative analgesia;
4. Preventive control programs;
5. Charges for failure to keep a schedule appointment;
6. Charges for completion of forms;
7. Charges for consultation;
8. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a Provider for treatment in any such facility;
9. Charges for treatment of, or services related to, temporomandibular joint dysfunction;
10. Dental procedures, services, treatment and supplies that are determined to be partially or wholly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Crowns placed on covered dependents under age 12, other than prefabricated crowns;
12. Prosthetics placed on covered dependents under age 16;
13. Appliances, restorations, or procedures for: (a) increasing vertical dimension; (b) restoring occlusion; (c) correcting harmful habits; (d) replacing tooth structure lost by attrition, erosion, abrasion, or abfraction; (e) correcting congenital or developmental malformations except in newly born children; (f) replacement, provisional and temporary services; (g) splints, unless necessary as a result of accidental injury;
14. Dental procedures, services, treatment or supplies provided by an individual other than a Provider;
15. Dental procedures, services, treatment or supplies to treat injuries or diseases caused by riots or any form of civil disobedience;
16. Dental procedures, services, treatment or supplies to treat injuries sustained while committing a felony or engaging in an illegal occupation;
17. Dental procedures, services, treatment or supplies to treat injuries intentionally inflicted;
18. Replacement of lost or stolen dentures or charges for duplicate dentures;
19. Dental procedures, services, treatment or supplies in cases for which, in the professional judgment of the attending Provider, a satisfactory result cannot be obtained;
20. Local anesthetic is covered as a part of a dental procedure, service or treatment. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures);
21. If orthodontic procedures are included as benefits under this dental Plan, the repair and replacement of orthodontic appliances is not covered;
22. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided;
23. Dental procedures, services, treatment or supplies excluded as provided in the Summary of Benefits;
24. Dental procedures, services, treatment or supplies not specifically covered under this dental Plan or excluded by Delta Dental rules and regulations, including Delta Dental processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

Coordination of Benefits

Applicability

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

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

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

Definitions

The following definitions apply to this Coordination of Benefits provision:

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

1. Nondependent/Dependent. The benefits of the Plan that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.

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

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

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

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

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

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

5. Continuation Coverage.
   a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:
      1) First, the benefits of a Plan covering the employee, member, or subscriber or dependent of an employee, member, or subscriber.
      2) Second, the benefits under the continuation coverage.
   b. If the other Plan does not have the rule described in subparagraph a., and if as a result, the Plans do not agree on the order of benefits, this paragraph 5. is ignored.

6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

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

Effects on the Benefits of this Plan

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

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

Eligibility

Eligibility and Enrollment Procedures

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Eligible Employee

You generally are eligible for coverage on the date your employment is classified as a .50 FTE or greater. However, Casual, PRN (employees hired pursuant to the terms of the PRN program to perform various assigned job functions), and employees in temporary positions such as Vacation/Leave Replacement positions, interns, or fellows may be eligible depending upon their hours and other factors. If your employer determines that you are not an employee for the purposes of the Plan because you are not reported on its payroll records as a common- law employee, then you will not be considered an employee for Plan purposes even if a court or administrative agency determines that you are or were a common-law employee and not an independent contractor.

If you currently have coverage and you transfer employment from one entity to another within the Plan, the waiting period is waived. If you are not covered at the time of transfer, you may enroll in coverage but may be subject to the waiting period.

Husband/Wife, Domestic Partnership and Stepparent Enrollment

If both you and your spouse/domestic partner are eligible employees of the employer, each may enroll for coverage in one of the dental plans as an eligible employee or be covered as a dependent of the other, but not both. If both parents (who are husband/wife, stepparents, or domestic partners) of an eligible dependent child are enrolled as an eligible employee, only one parent/stepparent may enroll the child as a dependent. No individual, including dependent children, can be covered by more than one dental plan offered under the Bellin Gundersen Health and Welfare Benefit Plan.

If both you and your spouse/domestic partner are eligible employees of the employer, and one of you disenroll from a dental plan under the Bellin Gundersen Health and Welfare Benefit Plan in the middle of the year due to a significant health premium cost increase, then the other may enroll for coverage in one of the dental plans offered under the Bellin Gundersen Health and Welfare Benefit Plan within 30 days of the date of the disenrollment corresponding with such disenrollment.

Eligibility of Dependents

You may cover your dependent(s) only if you are covered.

An eligible dependent is defined as your:

1. Your legal spouse, provided he or she is not covered as an Employee under this Plan. A legal spouse may include a spouse through a Common Law Marriage when the employee's state of residence recognizes a Common Law Marriage. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. The Plan Administrator

may require documentation of a covered person's marital status.

2. Domestic partner, an individual (same or opposite sex) with whom you have agreed to live as sole domestic partners in a relationship that is characterized by all of the following:
   - You have a committed spousal-type relationship of mutual support and caring, and you intend to remain in the relationship indefinitely.
   - Your domestic partnership is, and has been for the past six months, publicly acknowledged, and commonly recognized within the communities in which you live and work.
   - You share financial resources and have agreed to be responsible for each other's common welfare.

   You and your domestic partner attest to all of the following:
   - You are both 18 years of age or older.
   - You are both mentally competent to make the declarations required by the enrollment form.
   - You are not related by blood closer than would bar marriage in the state in which the employee resides.
   - For at least the past six months prior to your application for coverage in the benefit plans, all of the following have been true:
     i. You have lived together in the same dwelling unit;
     ii. Neither of you were married or legally separated in marriage;
     iii. Neither of you were a party to an action nor proceeding for divorce or annulment;
     iv. Neither of you were in another domestic relationship;
     v. You and your domestic partner were financially interdependent as evidenced by at least two of the following:
        - Common or joint ownership of a residence.
        - Joint ownership of a motor vehicle.
        - Joint credit account; for example, a credit card.
        - Joint checking or savings account.
        - Your domestic partner identified as primary beneficiary in your will, life insurance policy(ies), tax-sheltered annuity account(s), IRA(s), or other retirement accounts.
        - Joint financial investments.

   The Plan Administrator may require documentation of a covered person's domestic partner status.

   Note: You may cancel coverage for a domestic partner at any time during the year. A subsequent domestic partner cannot be added for at least 6 months. Coverage for your domestic partner will result in Income Tax as well as FICA and Medicare Tax implications. Contact a Benefits Specialist in your Human Resource Department for complete information regarding domestic partnership benefits.

3. A Dependent Child until the child reaches his or her 26th birthday. The term child includes the following dependents:
   - A natural biological child;
   - A stepchild;
   - A legally adopted child or child legally placed for adoption as granted by action of federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
   - A child under your (or your spouse's) legal guardianship as ordered by a court;

- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
- A child of a Domestic Partner or a Child under your Domestic Partner's legal guardianship as long as the Domestic Partner is covered under the plan;
- Effective 1/1/2025, the plan will no longer cover foster children who are placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction. Foster children who were covered under the plan prior to 1/1/2025, will remain as qualified dependents through the end of the month they reach age 26; or
- Effective 1/1/2024 the plan will no longer cover new Grandchildren born to a covered dependent. Grandchildren that were covered by the plan prior to 1/1/2024, will remain as qualified dependents through the end of the month such covered dependent (parent) reaches age 26.

A Dependent does not include the following:

- A foster Child, unless they meet the criteria outlined above;
- A grandchild, unless they meet the criteria outlined above;
- Any other relative or individual unless explicitly covered by this Plan; or
- A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Married or unmarried dependent children are covered through the end of the month they reach the age of 26.

We will not deny eligibility to your child or set a premium rate for your child based on financial dependency, residency with a parent, residency outside of the service area, whether or not you claim the child as a tax exemption, student status, or based on the fact that your child is eligible to enroll in other eligible employer-sponsored health plan coverage.

Extension of Dependent Child Coverage

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may ask for additional proof at any time. Coverage may continue subject to the following minimum requirements:

To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

1. A Totally Disabled Dependent Child aged 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
2. Such child is unmarried; and
3. Is incapable of self-sustaining employment due to physical or mental impairment.

Written proof of incapacity and dependency in a form satisfactory must be provided within 30 days after the dependent's attainment of age 26. We may request the dependent to be examined periodically by a participating provider for the purpose of determining the existence of the incapacity prior to granting continued coverage.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 30 days if Your dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any dental claims paid by the Plan during the period that the Dependent did not qualify for extended coverage.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

Effective Dates

The effective date is defined as the date on which you, and your eligible dependents, if any, become enrolled and entitled to benefits.

Effective Date of Employee's Coverage

Coverage begins the first day of the month following date of hire. For existing employees who become eligible following a change in position, coverage begins on the 1st of the month following the change in position. The waiting period does not apply to Medical, Sports Medicine, and Pharmacy Residents. If you become an employee of Bellin Gundersen Health System through an acquisition or a merger, the waiting period may be waived.

You have 30 days from your date of eligibility to enroll. If you do not enroll during this time, you will be considered a late enrollee, and you will not be able to enroll for coverage until the next annual open enrollment period, unless you qualify for enrollment pursuant to the Special Enrollment provisions described herein.

If you are eligible to enroll under the Special Enrollment provision, your coverage will become effective on the date set forth under the Special Enrollment provision if application is made within 30 days of the event.

Effective Date of Coverage for Your Dependents

Your Dependent's coverage will be effective on the later of:

1. The date your coverage under the plan begins if you enroll the Dependent at that time;
2. The date you acquire your dependent if application is made within 30 days of acquiring the dependent;
3. The date set forth under the Special Enrollment provision if your dependent is eligible to enroll under the Special Enrollment provision and if application is made within 30 days of the event;
4. The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A covered dependent child who becomes an eligible employee for coverage under this plan may be covered as an eligible employee or be covered as a dependent, but not both.

No dependent's effective date will be prior to your effective date of coverage.

Newborns

You have 30 days from the date of birth of a child to submit an enrollment form for dependent coverage of the newborn. Dependent coverage will take effect on the date of birth. You must pay all past premiums for coverage back to the date of birth. If you apply for dependent coverage more than 30 days after the newborn's birth date, the child will be considered a late enrollee and you will not be

able to enroll for coverage until the next annual open enrollment period, unless you qualify for enrollment pursuant to the Special Enrollment provisions described herein.

Adopted Children and Children in Adoptive Placement

Coverage for an adopted child is effective on the date a child is placed by court order in your home for purposes of adoption or is legally adopted. You have 30 days from the adoption or placement for adoption to enroll for dependent coverage. You must notify your employer that the child is adopted or placed for adoption and pay any premium required to provide coverage for the child within 30 days. If you apply for dependent coverage more than 30 days after the adoption date or placement for adoption the child will be considered a late enrollee and you will not be able to enroll for coverage until the next annual open enrollment period, unless you qualify for enrollment pursuant to the Special Enrollment provisions described herein.

Medical Child Support Orders

If a court orders you to provide coverage for a child's health care services, and you are eligible for family coverage under the Plan, you, the child's other parent, the Department of Health and Family Services (DHFS) or the county designee will enroll the child, if eligible for coverage without regard to any enrollment period restrictions upon application. After the child is covered under the Plan and as long as the child is eligible for coverage, we will continue to provide coverage for the child unless we receive written evidence that the court order is no longer in effect or that the child has other comparable health insurance coverage. We may use the same factors to determine eligibility and premium rates for a child who is the subject of a medical child support order as we do for other dependents.

If we provide coverage under the Plan for your child, and you are not the custodial parent, we will do all of the following: 1) provide the custodial parent with information relating to the child's enrollment; 2) permit the custodial parent, a health care provider of the Department of Health and Family Services (DHFS) to submit claims for covered services without your approval; and 3) pay claims directly to the health care provider, the custodial parent or the DHFS. A court order documenting custody is required.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

Annual Open Enrollment Period

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

Special Enrollment Period

If you previously waived coverage under the Plan for yourself or any eligible dependents because you were covered under a group health plan or had health insurance coverage at the time coverage was previously offered, we will permit you and your eligible dependents to be enrolled for coverage under the Plan when you provide us with written proof that the previous coverage ended due to:

1. Your exhaustion of COBRA continuation of coverage;
2. Your involuntary loss of other coverage due to a loss of eligibility for coverage because of events such as Legal Separation, divorce, termination of domestic partnership, death, employment termination, reduction in hours, or no longer qualify as a dependent child;
3. Employer contributions to the plan terminated.

We must receive the written documentation of your qualifying loss of coverage within 30 days of the coverage termination date along with your completed enrollment information. If received within the 30-day timeframe, the coverage for the employee and/or dependents will be effective the date of the qualifying event. If you enroll for coverage after the 30-day time period you and your eligible dependents will be considered a late enrollee, and you will not be able to enroll for coverage until the next annual open enrollment period, unless you qualify for enrollment pursuant to the Special Enrollment provisions described herein.

The general rule for special enrollment is that you must provide written documentation related to your enrollment need within 30 or 60 days. However, you may be entitled to an extension of this deadline depending upon your specific situation. If you have questions about this deadline, please contact your regional Benefits Department. When leaving a voice message after business hours, please be sure to include your first and last name, a telephone number where we can reach you, and we will respond to you no later than one business day.

A Special Enrollment Period Does Not Apply

1. During a COBRA extension period; or
2. If the qualifying coverage is voluntarily terminated.

A Special Enrollment Period Applies

1. If the employee marries;
2. If the employee enters into a qualifying domestic partnership;
3. A child is born to the employee;
4. A child is adopted or placed for adoption; or
5. A child is placed under your legal guardianship.

Persons Eligible to Enroll During a Special Enrollment Period Include

1. The employee and the new spouse/domestic partner;
2. The employee, spouse/domestic partner, dependent step-children and dependent children not previously covered;
3. The employee, spouse/domestic partner, newborn child, and other dependent children not previously covered; or
4. The employee, spouse/domestic partner, adopted child, and other dependent children not previously covered.

A Special Enrollment Period Arises When

1. An individual has a loss of eligibility under another plan because that plan no longer offers any benefits to a class of similarly situated individuals.

Special Enrollment Due to Marriage/Domestic Partnership, Birth or Adoption

The Plan provides a 30-day enrollment period for persons who become a dependent through marriage, qualifying domestic partnership, birth, adoption or placement for adoption. This enrollment period begins with the day of the qualifying event, i.e., marriage, qualifying domestic partnership, birth, adoption, placement for adoption. If an employee or their dependent previously waived coverage under the Plan, they are also eligible to enroll during this enrollment period if they are otherwise eligible. Coverage becomes effective:

1. In the case of marriage, on the day of marriage;
2. In the case of qualifying domestic partnership, the date qualifications are met;
3. In the case of birth, the date of birth;
4. In the case of adoption, on the earlier of the date of adoption or placement for adoption; and
5. In the case of a legal guardianship, on the date on which such child is placed in the covered employee's home pursuant to a court order appointing the covered employee as legal guardian for the child.

Medicaid and State Children's Health Insurance Program (CHIP)

A special enrollment right is available to you and your dependents if you or your dependents are covered under Medicaid or CHIP coverage and coverage is terminated as a result of loss of eligibility. Coverage for you and your dependents will be effective the date of the qualifying event if the completed enrollment form is received within 60 days from the qualifying event. Also, a special enrollment right is available to you and your dependents if you or your dependents become eligible for a state premium assistance subsidy from Medicaid or CHIP. Coverage may be cancelled provided you complete a cancellation form, and the form is received within 60 days from the qualifying event.

Family Status Changes

You may add or delete coverage for yourself and/or your eligible dependents if you experience a family status change during the year. You are also allowed to change the plan you are enrolled in at this time. You will have 30 days from the date of the event to notify the Plan Administrator's Human Resource Department and change your election. The following are events that are considered a change in family status:

1. Your marriage, domestic partnership, divorce, Legal Separation, or termination of domestic partnership;
2. Birth or adoption of a child, stepchild, or grandchild (provided the grandchild's parent is a covered
   dependent and the grandchild was born before 1/1/2024);
3. Death of a family member;
4. Your spouse/domestic partner loses coverage under his or her employer's plan due to: termination of employment, reduction in hours, or the employer terminates all medical plans;
5. The eligibility status changes for a covered dependent; or
6. You or your dependents gain other coverage.

Cost of Coverage Increase

If the cost of coverage under a plan option is significantly increased, the Plan Administrator may permit you to disenroll in the Plan within 30 days from the date of the change.

When Coverage Ends

A covered person's coverage under the plan terminates when any of the following events occur:

1. The date the plan terminates;
2. The date the plan terminates;
3. The end of the period for which your last contribution is made if you fail to make any required contribution toward the cost of coverage when due;
4. The date employment ends;
5. The date employee ceases to meet eligibility requirements or is no longer in a class of employees who are eligible for coverage under the plan;
6. The date employee requests voluntary termination for themselves and/or covered dependents upon a qualifying event; or
7. In the event of misrepresentation or omission of a material fact by the Covered Person regarding eligibility, enrollment, other coverage, claims or other expense, the Plan Sponsor has the right to rescind this SPD or disenroll the covered person.

Dependent Eligibility ceases for:

1. The end of the period for which your last contribution is made if you fail to make any required contribution toward the cost of your dependent's coverage when due;
2. The day of the month in which your coverage ends;
3. The day of the month in which your dependent is no longer your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside;
4. The day of the month in which your dependent no longer qualifies as a domestic partner;
5. For child(ren) of a domestic partner, the day of the month in which the domestic partnership terminates;
6. The last day of the month in which your dependent child attains the limiting age listed in the Eligibility of Dependents section;
7. If your dependent child qualifies for extended dependent coverage because he or she is Totally Disabled, the last day of the month in which they are no longer deemed Totally Disabled under the plan;
8. The day of the month in which your dependent child no longer satisfies the required eligibility criteria listed in the Eligibility of Dependents section;
9. The date employee requests voluntary termination for their domestic partner and/or the domestic partner's children; or
10. In the event of misrepresentation or omission of a material fact by the covered person regarding eligibility, enrollment, other coverage, claims or other expense, the Plan Sponsor has the right to rescind this SPD or disenroll the covered person.

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

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

All benefits cease on the day coverage terminates. A dental procedure is incurred on the date it is completed. Dental procedures are considered for benefits if they are incurred during the contract term and a claim is filed within 15 months from the date it is incurred.

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.

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

Uniformed Services Employment and Reemployment Rights Act

If you are going into or returning from military service, you may have special rights to coverage under this dental Plan under the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights can include extended coverage. If you may be affected by this law, ask your Plan Administrator for further details.

Federal Continuation Provisions (COBRA)

Continued Coverage

If your employer employs more than 20 employees, Title X of the Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA) applies. Under COBRA, if you and your covered dependents were covered under this Plan the day before a Qualifying Event, you are "Qualified Beneficiaries" and may elect continuation of dental coverage under this Plan. COBRA defines a Qualifying Event as:

For the Subscriber:

1. The termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. The reduction of hours to fewer than the minimum required for coverage under this dental Plan.

For Covered Dependents:

1. If the covered dependent is the subscriber's spouse:
   a. Death of subscriber; or
   b. Termination of subscriber's employment, except for reasons of gross misconduct; or
   c. Reduction of subscriber's hours to fewer than the minimum required for coverage under this dental Plan; or
   d. Divorce or legal separation from subscriber; or
   e. Subscriber's Medicare entitlement.

2. If the covered dependent is the subscriber's child:
   a. Child ceases to be a dependent; or
   b. Death of subscriber; or
   c. Termination of subscriber's employment, except for reasons of gross misconduct; or
   d. Reduction in subscriber's hours to less than the minimum required for coverage under this dental Plan; or
   e. Subscriber's Medicare entitlement; or

f. Parents become divorced or legally separated.

The group must provide notice to a Qualified Beneficiary of the right to elect COBRA continuation coverage.

A covered dependent whose coverage is terminated due to divorce, legal separation or cessation of eligibility for dependent coverage must provide the group with notice of such event within 60 days of its occurrence.

The Qualified Beneficiary must make an election of continuation coverage within 60 days beginning on the later of the date of the Qualifying Event or the date the Qualified Beneficiary receives notice of COBRA election rights. The COBRA election by a subscriber or a subscriber's covered spouse is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the covered beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

1. Eighteen months for all Qualified Beneficiaries after the subscriber's employment termination or reduction in hours.
2. Twenty-nine months after the Qualifying Event for a subscriber or covered dependent who is determined to be disabled under the Social Security Act prior to the 60th day of COBRA coverage and the disability continues during the rest of the 18-month COBRA coverage period. The disabled Qualified Beneficiary must notify the Plan of the disability determination within the first 18 months of COBRA coverage. Coverage will also be continued for any non-disabled family member who is a Qualified Beneficiary with respect to the same Qualifying Event.
3. For Qualified Beneficiaries other than the subscriber who experience a second Qualifying Event, 36 months after the date of the initial Qualifying Event.
4. The date on which the Qualified Beneficiary receiving continuation coverage fails to make a timely payment of premium. Delta Dental will not reinstate COBRA continuation coverage once terminated for nonpayment of premium.
5. The date on which the group ceases to offer this dental Plan to any of its employees or members.
6. The date on which coverage begins under another group dental plan; however, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.
7. The date the Qualified Beneficiary becomes entitled to Medicare benefits.

The first Premium must be paid to the group within 45 days of the election of COBRA continuation coverage. Future Premium payments must be paid by the first day of each month.

Under ERISA Section 602(3), premium for a Qualified Beneficiary will not exceed 102% of the single, family, or other applicable monthly Rate in effect for the group, except that the premium for a Qualified Beneficiary who becomes disabled during the first 60 days of COBRA coverage will be 150% of the single, family, or other applicable monthly Rate in effect for the group during months 19 through 29 of COBRA coverage.

If you have any questions about continued dental coverage, the human resources department at your company can help you.

Rights of Recovery (Subrogation)

If expenses are paid on your behalf under this Plan, the Plan is entitled to all rights of recovery you may have against any other person for those expenses to the extent of the Plan's payment. The Plan can subrogate only if you are fully compensated for all damages, taking into consideration your comparative negligence. You must sign and deliver to the Claims Administrator, Delta Dental, any legal papers relating to the recovery, help exercise these rights and do nothing to harm these rights. If you are fully compensated for all expenses, you must repay the Plan to the extent of the Plan's claim payments.

Date: 06/18/2025

IV. Claims Procedures

Claims Administrator Liability

Delta Dental serves only as the Claims Administrator for this Plan. In no instance is Delta Dental liable for any conduct, including but not limited to tortious conduct or wrongful acts or omissions, by any person providing services to subscribers and covered dependents under this Plan, including but not limited to providers, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services. In no instance is Delta Dental liable for services of facilities that, for any reason, are unavailable to a subscriber or covered dependent.

Prior Approval of Benefits

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

How to Contest a Claim Denial

Denial of a Claim for Benefits

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

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

Appealing a Claim Denial (Filing a Grievance)

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

To 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 member number on all supporting documents.

You must make your request within 180 days of the date of the initial benefits determination denying your claim for benefits.

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

Within 30 days of receiving your request, Delta Dental will send you the written decision and indicate any action taken. (Special circumstances may require 60 days.)

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

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

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

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

If you have any questions, please contact the Claims Administrator:

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

V. Statement of ERISA Rights

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

Receive Information about Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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.