Summary Plan Description

Delta Dental PPO

for

FOTH & VAN DYKE, LLC
FOTH PRODUCTION SOLUTIONS, LLC
FOTH INFRASTRUCTURE & ENVIRONMENT, LLC
FOTH ASSET MANAGEMENT, LLC

BASE PLAN

90800

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I. Plan Description Information

1. **Plan Name:** Foth & Van Dyke, LLC Group Dental Plan

2. **Plan Sponsor:** Foth & Van Dyke, LLC
2121 Innovation Court, Suite 100
P.O. Box 5095
De Pere, WI 54115-5095

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

Foth & Van Dyke, LLC
2121 Innovation Court, Suite 100
P.O. Box 5095
De Pere, WI 54115-5095
920-497-2500

4. **Plan Sponsor's Employer Identification Number (EIN):** 20-5814203.
The Plan number assigned for government reporting purposes is 507.

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, 2017.

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

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

Foth & Van Dyke LLC
2121 Innovation Court, Suite 100
P.O. Box 5095
De Pere, WI 54115-5095

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

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

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

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

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

II. Description of Benefits

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

Delta Dental PPO Dentists

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

Dentists Outside the Delta Dental PPO Network

Delta Dental Premier Dentists

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

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

Noncontracted Dentists

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

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

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

Maximum Plan Allowance (MPA)

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

Filing Claims

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

Predetermination of Benefits

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

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

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

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

Optional Treatment

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

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: 90800

Effective Date of Program: January 1, 2002

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

Deductibles:

Per Person, per Benefit Accumulation Period:	$75.00
Per Family, per Benefit Accumulation Period:	$150.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period:	$750.00 *
Additional Implant Benefit per Person:	$750.00

This Plan does not provide an orthodontic benefit.

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

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

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

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

This Plan does not provide an orthodontic benefit.

** 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 Dentists are required to set the appropriate health condition indicator online at www.deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin.

The EBICP benefits are as follows:

Periodontal Disease

1. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

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

Diabetes

1. With an indicator of 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 in this Summary Plan Description.

Kidney Failure or Dialysis Conditions

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

Cancer Related Chemotherapy and/or Radiation

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

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

Diagnostic and Preventive Procedures – 100% (deductible waived)

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. If necessary due to injury, 3-year limitation is waived.
3. Bitewing x-rays once per calendar year, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) twice in a benefit year.

5. Periodontal prophylaxis twice in a benefit year.
6. Topical fluoride applications twice in a benefit year, for dependent children to age 18.
7. Space maintainers for retaining space when a primary tooth is prematurely lost.
8. 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 in a 4-year period.

Basic Restorative Procedures – 100% (deductible waived)

1. Brush biopsy.

Basic Restorative Procedures – 80% (deductible applies)

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. 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 1 year; surgical treatment once each 3 years.
7. Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a benefit once in any 36-month period.
8. Coverage for the purpose of recementing a defective existing crown, inlay, onlay, fixed bridge or partial/complete denture.

Major Restorative Procedures – 50% (deductible applies)

1. Crowns, inlays or onlays, when teeth are broken down by decay or accidental injury and may no longer be restored adequately with a filling.
2. Prosthetics (fixed bridgework, partial or complete dentures to replace missing permanent teeth);
   a. 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. The 5-year replacement limit is waived if replacement is due to injury.
   b. 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.
   c. implants and all procedures relating to implants including, but not limited to, implant, attachment and crown.

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

Exclusions

This dental plan does not provide coverage for the following:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer's Liability Laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this dental plan.
3. Prescription drugs, premedications or relative analgesia; charges for anesthesia other than charges by a licensed dentist for administering general anesthesia in connection with covered oral surgery (cutting procedures); preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
4. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
5. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
6. Services that are determined to be partially or wholly cosmetic in nature.
7. Cast restorations placed on eligible patients under age 12; prosthetics placed on eligible patients under age 16.
8. Appliances or restorations for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; or for splints, unless necessary as a result of accidental injury.
9. Treatment by other than a licensed dentist, his or her employees, or his or her agents.
10. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
11. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided.
12. Replacement of lost or stolen dentures or charges for duplicate dentures.
13. Treatment or services covered under a medical plan are not covered under this dental plan.
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.
15. Orthodontic benefits.

Coordination of Benefits

Benefits are coordinated when more than one plan provides dental coverage for you and your dependents.

Benefits described in this Plan are coordinated with benefits provided by other plan for which you are also covered. This Plan contains a provision called non-duplication of benefits. This means that the Plan works with other group plans that provide you with benefits. If your Plan benefits are greater than the benefits paid by the primary plan, the Plan will pay the difference between Plan benefits and the primary plan's benefits. If the amount paid by the primary plan is the same or greater than your Plan's benefits, no payment is made.

The Coordination of Benefits provision establishes which Plan has primary responsibility for first payment on a claim.

Determining Which Plan is Primary

When a husband and a wife work for different firms, they may have coverage under two group plans. The plan covering the patient as the employee has responsibility for providing benefits before the plan covering the patient as a dependent.
If the patient is a ***dependent child***, the plan of the parent whose birth date is earlier in the calendar year (month and day only) is primary.

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

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

The benefits of a plan covering a person as an ***active employee*** (neither laid off nor retired) or as such an employee's dependent are determined before those of a plan covering the person as ***inactive*** (laid off or retired) or as such an employee's dependent. If another plan does not have this rule and this results in a disagreement on which plan is primary, this rule is ignored.

If you have ***continuation coverage*** under federal or state law and are also covered under another plan, the benefits of a plan covering you as an employee, member or subscriber or as a dependent of an employee, member or subscriber are determined first, then the continuation coverage next. If another plan does not have a continuation coverage rule and this results in a disagreement on which plan is primary, this rule is ignored.

Eligibility

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. The Plan may request documentation from you or your Dependents in order to make these determinations. The coverage choices that will be offered to you will be the same choices offered to other similarly situated Employees.

Eligibility Requirements

An eligible Employee must be in active employment in the United States with the employer and an employee who is classified by the employer on both payroll and personnel records to be regularly scheduled to work at least 25 hours or more per week, but for purposes of this plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Contract personnel or leased Employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time or part-time basis meeting the requirements of an eligible Employee as described above.
- Temporary, limited term full-time, and limited term part-time employees. See Payroll Program Summary of Policies section of the Member Practices Handbook for additional information regarding member employment status.

If you are temporarily absent from work due to an approved leave of absence or layoff for medical or other reasons, your coverage under this plan will continue during that leave/layoff, provided that the applicable employee contribution is paid when due. Eligibility during an approved leave of absence or layoff will be subject to the terms and conditions of the employer's leave/layoff policy, subject to employer's discretion, but will not exceed 180 calendar days.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group

health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

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

Coverage is not available to you if you are eligible for dental coverage under another group dental plan as an employee or retired employee.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which you reside, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom you have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.
- Your Domestic Partner, so long as he or she meets the definition of Domestic Partner as stated below and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as your Dependent.

A Non-Registered Domestic Partner:

A Non-Registered Domestic Partner means an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence and who is not married or legally separated from anyone else.

In order for your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, caring and commitment and are responsible for each other's welfare;
- Have maintained this relationship and intend to do so indefinitely;
- Have shared a primary residence and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent;
- Meet any of the other requirements identified in the Plan Sponsor's Affidavit of Domestic Partnership and otherwise agree to the terms in the affidavit.

Registered Domestic Partner:

> Registered Domestic Partner means that You are registered with any state or local government that offers a domestic partner registry. A copy of the registration must be provided to the Plan Sponsor within 90 days of the date the Registered Domestic Partner became eligible for coverage under this Plan.

A Dependent Child until the child reaches his or her 26th birthday unless stated otherwise below. The term "Child" includes the following Dependents:

1. A natural biological child;
2. A stepchild;
3. A legally adopted Child or a Child legally Placed for Adoption as granted by action of a 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;
4. A child under Your (or Your Spouse's) Legal Guardianship as ordered by a court or until the child reaches his or her 21st birthday, whichever is greater, but not to exceed their 26th birthday;
5. A child who is considered an alternate recipient under a Qualified Medical Child Support Order.
6. A foster child as ordered by a court, or until the child reaches his or her 21st birthday, whichever is greater, but not to exceed their 26th birthday.
7. A child of a Registered Domestic Partner; as long as that child meets the definition of a Child under paragraphs 1., 3., 4. or 6. above.

A dependent does not include the following:

1. A Child of a non-registered Domestic Partner or under Your non-registered Domestic Partner's Legal Guardianship;
2. A grandchild; (unless otherwise qualifies as a "child" as defined above)
3. Any other relative or individual unless explicitly covered by this Plan.
4. A dependent Child if the Child is covered as a dependent of another Employee at this company.

Right to Check a Dependent's Eligibility Status

The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify your Human Resources Department regarding status changes.

Extended Coverage for Dependent Children

If you have a Dependent who is Totally Disabled, either mentally or physically, and that child was Totally Disabled AND enrolled in this Plan as of 12-31-2013, 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. The Plan may, for two years, ask for additional proof at any time, after which the Plan can

ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof must be submitted as required (Notice of Award of Social Security Income is acceptable); and
- The Employee must still be covered under this Plan.

IMPORTANT: It is your responsibility to notify the Plan Sponsor within 60 days if your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent does not meet the qualifications of Totally Disabled, 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. Please refer to the COBRA Section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

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 Date of Employee's Coverage

Your coverage will begin on the later of:

- If you apply within 30 days of hire, your coverage will become effective your date of hire; or
- If you apply more than 30 days from your date of hire, your application will be rejected, and you will not be eligible to enroll until either you experience a Special Enrollment event (see below), or the next annual enrollment period; or
- 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:

- The date your coverage with the Plan begins if you enroll the Dependent at that time; or
- The date you acquire your Dependent if application is made within 30 days of acquiring the Dependent; or
- If you request coverage for your Dependent more than 30 days of your hire date, or more than 30 days following the date you acquire the Dependent; your application will be rejected, and you will not be able to enroll your Dependent until either you or your Dependent experience a Special Enrollment event (see below), or the next annual enrollment period; or

- If your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The date specified in a Qualified Medical Child Support Order.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will your Dependent be covered prior to the day your coverage begins.

Termination of Coverage

Please see the COBRA section of this SPD for questions regarding coverage continuation.

Employee's Coverage

Your coverage under this Plan will end on the earliest of:

- The end of the period for which your last contribution is made, if you fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for your benefit class is canceled; or
- The day of the month in which you tell the Plan to cancel your coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The day you cease to be **an eligible Employee**, as defined by the Eligibility Requirements as Determined by the employer except as follows:
    - If you are temporarily absent from work due to an approved leave of absence or layoff for medical or other reasons, your coverage under this Plan will continue during that leave/layoff, provided that the applicable Employee contribution is paid when due. Eligibility during an approved leave of absence or layoff will be subject to the terms and conditions of the employer's leave/layoff policy, subject to employer's discretion, but will not exceed 180 calendar days.
    - If you are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
- The day of the month in which your employment ends; or
- The date you submit a false claim or are involved in any other form of fraudulent act related to this Plan.

Your Dependent's Coverage

Coverage for your Dependent will end on the earliest of the following:

- 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; or
- The day of the month in which your coverage ends; or
- 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 where the Employee resides; or

- The day of the month in which your Dependent no longer qualifies as a Domestic Partner; or
- The last day of the month in which your Dependent child attains the limiting age listed under the Eligibility section, unless the child qualifies for Extended Dependent Coverage; or
- If your Dependent child qualifies for Extended Dependent Coverage as Totally Disabled, the day of the month in which your Dependent child is no longer deemed Totally Disabled under the terms of the Plan; or
- The date Dependent coverage is no longer offered under this Plan; or
- The day of the month in which you tell the Plan to cancel your Dependent's coverage if you are voluntarily canceling it while remaining eligible because of change in status, special enrollment or at annual enrollment periods; or
- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date you or your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan.

Changes in Coverage

You may change your enrollment in this dental plan if there is a family status change. The enrollment change will be effective as determined by Foth & Van Dyke. Notification of the enrollment change must be received by Delta Dental within 30 days of the change.

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

Notices

Notice to Foth & Van Dyke 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 Foth & Van Dyke. It is the responsibility of Foth & Van Dyke to notify you regarding changes or termination of your coverage.

Termination of Coverage

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 one year after the date it is incurred. If the agreement between Delta Dental Plan and Foth & Van Dyke terminates, this document no longer describes the benefits of your dental plan.

Federal Continuation Provision (COBRA)

Continued Dental Coverage

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

Qualifying Event for Continued Coverage

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

Continued Coverage for Employees

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

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

Continued Coverage for the Spouse of an Employee

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

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

Continued Coverage for a Dependent Child

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

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

Length of Continued Coverage

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

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

Notification Process

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

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

Termination of Continued Coverage

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

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

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

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

III. 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 dentists, 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 dentist 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 dentist, will receive written notification within 30 days after your claim is received, unless special circumstances require an extension of time for processing. The decision will be sent on a form entitled "Explanation of Benefits."

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

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact Delta Dental at 800-236-3712. Because most questions about benefits can be answered informally, 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 that the Plan formally review 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 Social Security 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 Plan's written decision and indicate any action the Plan has 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 Plan's 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 against the Plan 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

IV. Statement of ERISA Rights

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

Receive Information About Your Plan and Benefits

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