Summary Plan Description

Delta Dental PPO

for

FAITH TECHNOLOGIES, INC.

54306

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I. Plan Description Information

1. Plan Name: Faith Technologies, Inc. Group Dental Plan

2. Plan Sponsor: Faith Technologies, Inc.
2662 American Drive
Appleton, WI 54914

3. Plan Administrator and Named Fiduciary:

Faith Technologies, Inc.
2662 American Drive
Appleton, WI 54914
920-225-6545

4. Plan Sponsor's Employer Identification Number (EIN): 41-2065665
The Plan number assigned for government reporting purposes is 501.

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

6. Plan benefits described in this booklet are effective January 1, 2015.

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

8. Agent for service of legal process:

Faith Technologies, Inc.
2662 American Drive
Appleton, WI 54914

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. Effective 1/1/06, the plan will pay approximately 80% of the total annual premium for employees (subject to change).

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.
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Summary of Benefits

Group Number: 54306

Effective Date of Program: January 1, 2006

Dependents to Age: 26
(Please see "Covered Dependents" in the "Eligibility" section for requirements).

Deductibles:

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

Benefit Maximums:

Per Person, per Benefit Accumulation Period:	$1,000.00
Per Family, per Benefit Accumulation Period:	$3,000.00
Orthodontic Maximum Benefit per Lifetime Per Dependent Child to age 19:	$2,000.00

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	**80%***	**80%***
Major Restorative Procedures	**80%***	**80%***
Orthodontic Procedures	**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 percentage 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

1. Examinations twice per calendar year.
2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays once per calendar year, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) twice per calendar year.
5. Topical fluoride applications twice per calendar year, for dependent children to age 14.
6. Topical application of sealants for dependents to age 19. Application is limited to the occlusal surface of molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.
7. Space maintainers for retaining space when a primary tooth is prematurely lost.

Basic Restorative Procedures

1. Emergency exams and treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care, other than those specifically covered under the Medical Plan.
3. *a*. amalgam (silver) restorations;
   b. composite (tooth-colored) restorations;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.
4. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery.
5. Endodontics (root canal treatment and root canal fillings) — 1 per tooth in a 2-year period.
6. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical treatment once per quadrant per year; surgical treatment once every 3 years.

Major Restorative Procedures

1. Crowns, inlays or onlays, when teeth are broken down by decay or accidental injury and may no longer be restored adequately with a filling.
2. Prosthetics (fixed bridgework, partial or complete dentures to replace missing permanent teeth);
   a. repairs and adjustments to prosthetic appliances;
   b. denture reline and rebase once in any 3-year period;
   c. porcelain veneers on crowns or pontics on the 6 front teeth, bicuspids and upper first molars;
   d. replacement of a defective existing crown, inlay, onlay, fixed bridge or partial or complete denture only after 5 years from the date on which it was last supplied, regardless of who provided payment for the service unless replacement is needed due to accidental injury;
   e. fixed bridges and partial or complete dentures where chewing function is impaired due to missing teeth. Complete or partial dentures should be constructed when needed to replace missing teeth. Fixed bridges are a benefit only if the use of a removable prosthetic appliance is inadequate.

Orthodontic Procedures

Orthodontic services include orthodontic appliances and treatment, and related services for orthodontic purposes, including examinations, x-rays, extractions, photographs, study models, etc., for persons eligible as stated on the Summary of Benefits page.

Your coverage includes orthodontic treatment in progress. Delta Dental's payment for orthodontic treatment in progress extends only to the unearned portion of the treatment. Delta will determine the unearned amount eligible for coverage.

Repair or replacement of orthodontic appliances is not covered by this dental plan.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental will pay only for services and supplies actually received. No benefits are available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: One-fourth of the total case fee is considered the initial or down payment fee. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percent stated on the Summary of Benefits page.

Exclusions

This dental plan does not provide coverage for the following:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer's Liability Laws.
2. Services or appliances, including prosthetics (crowns, bridges or dentures), started prior to the date the patient became eligible under this dental plan.
3. Prescription drugs, premedications; 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, restorations, or procedures for increasing vertical dimension; for restoring occlusion; 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. Dental Procedures in cases for which, in the professional judgment of the attending Dentist, a satisfactory result cannot be obtained.
13. Replacement of lost or stolen dentures or charges for duplicate dentures.
14. Procedures or benefits not specifically provided under this dental plan or excluded by Delta Dental rules and regulations, including Delta processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

Coordination of Benefits

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

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

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

Determining Which Plan is Primary

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

If the patient is a ***dependent child***, the plan of the parent whose birth date is earlier in the calendar year (month and day only) is primary.
If the patient is a dependent child of separated or divorced parents and two or more plans cover the child, the plan of the parent with custody of the child is primary. The plan of a spouse of the parent with custody of the child is secondary, and lastly the plan of the parent not having custody.

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

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

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

Eligibility

Covered Employee

You are covered by this dental plan while you are an eligible employee of the group and have elected to participate in this coverage.

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.

Covered Dependents

If you are enrolled for family coverage, the following persons are covered under this dental Plan as your dependents:

1. Your lawful spouse;
2. Your children, including step and adopted children and children placed for adoption with you, who are less than 26 years of age;
3. Dependent children age 26 and over who are incapable of supporting themselves because of physical or mental incapacity that began prior to their 26th birthday or the date you became eligible for this dental plan.

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

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

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.

Effective Dates of Coverage

You are covered by this dental plan the first of the month following 60 consecutive calendar days of full-time employment, unless otherwise specified by the plan.

Your eligible dependents are covered beginning the first day you become covered under the dental plan, providing you have elected coverage for your dependents.

Changes in Coverage

You may change your enrollment in this dental plan if there is a qualifying event. The enrollment change will be effective as determined by the group. Notification of the enrollment change must be received by us within 30 days of the change.

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

Notices

Notice to the group or Delta Dental will be considered sufficient if mailed to their regular office address. Notices to you, as a subscriber, will be considered sufficient if mailed to your last known address or the last known address of the group. It is the responsibility of the group to notify you regarding changes or termination of your coverage.

Termination of Coverage

Your coverage and that of your eligible dependents ceases on the last day of the month in which you or your dependents are no longer eligible or on the day this dental plan is terminated.

If the agreement between Delta Dental Plan and the group terminates, this document no longer describes the benefits of your dental plan.

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

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

Coverage Pursuant to Qualified Medical Child Support Order

The Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support orders (QMCSOs). The Plan Administrator will develop written procedures to determine whether a medical child support order is a QMCSO and to administer the provision of Plan Benefits pursuant to QMCSOs. Subscribers and dependents may obtain, without charge, a copy of the QMCSO procedures from the Plan Administrator.

Upon receiving a medical support order, the Plan Administrator will promptly notify the affected dependent and each alternate recipient that the order has been received and describe the Plan's procedures for determining whether the medical child support order is a QMCSO. Within a reasonable period after receiving a medical child support order, the Plan Administrator will determine whether such an order is a QMCSO and will notify the subscriber and each alternate recipient of such determination.

Federal Continuation Provisions (COBRA)

Continued Dental Coverage

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") allows you to continue your dental coverage in certain circumstances where your coverage through a group dental plan would otherwise end. This section contains a description of your rights and obligations with respect to such continuation coverage including, among other things, information concerning qualifying events, premiums, your obligation to pay, notice and election requirements and procedures and duration of coverage.

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 COBRA.

Continued Coverage for Employees

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

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 of any of the following qualifying events:

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. Continued 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 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.

Length of Continued Coverage

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

***18 months**:* If qualifying event is job termination other than for gross misconduct 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.

Election Procedures

Your employer will advise the Plan Administrator if you lose coverage under the Plan due to one of the qualifying events listed. Your human resources department or the Plan Administrator will notify you of your options for continuation coverage and the Plan's monthly premium costs. You will then have up to 60 days to decide whether to purchase continued coverage. It will be your responsibility to pay for continuation coverage if you elect it.

You will have 45 days from the time you elect continuation coverage to pay your first premium, which premium must cover the period from when you lost coverage until your first payment. Thereafter, it will be your responsibility to pay the monthly premium by the grace period for each due date set by the Plan Administrator.

The Trade Act of 2002 provides a second 60-day COBRA election period for certain individuals who become eligible for trade adjustment assistance ("TAA") pursuant to the Trade Act of 1974. If you are either an eligible TAA recipient and did not elect continuation coverage during the 60-day COBRA election period that was a direct consequence of the TAA-related loss of coverage, you may elect continuation coverage during a 60-day period that begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed. However, the time between the loss of coverage and the start of the second election period will not be

counted for purposes of determining whether the individual has had a 63-day break in coverage under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Notification Procedures

If your spouse or dependent child experiences one of the qualifying events listed above, you or the person seeking the COBRA continuation coverage must notify your employer within 60 days of the occurrence of the qualifying event. Your spouse or dependent child will be informed of his or her continuation options and will have 60 days from the qualifying event or notice of the qualifying event to decide whether to purchase the coverage.

If you elect continuation coverage and your maximum period is 18-months, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your Plan Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may cause you to forfeit the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration ("SSA") to be disabled. The disability has to have started within the first 60 days of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **You must provide a copy of the determination letter and notify the Plan Administrator** before the end of the 18 month continuation coverage period AND within the later of (i) 60 days after the SSA makes its determination of your disability or (ii) 60 days after your continuation coverage begins. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. <u>If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within 30 days after SSA's determination.</u>

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the first event. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan Administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Termination of Continued Coverage

Continued coverage following a qualifying event is a right provided by COBRA. However, continued dental coverage can be terminated for any of these reasons:

1. You fail to make a timely premium payment.
2. Your employer ceases to offer a group dental plan.
3. Coverage begins under another group dental plan that does not contain a pre-existing condition exclusion.
4. An individual enrolls in and becomes entitled to Medicare after electing COBRA continuation.
5. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If you have any questions about continued dental benefits, the human resources department at your employer or your Plan Administrator should be able to 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, including any award for loss of employment or pain and suffering, 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: 10/07/2014

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 5 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 (7) 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 3 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 this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Action By Plan Fiduciaries

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