Summary Plan Description

Delta Dental PPO

For

WALWORTH COUNTY

92216

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I. Plan Description Information

1. Plan Name ("Plan"): Walworth County Group Dental Plan

2. Plan Sponsor:
   Walworth County
   100 W. Walworth Street
   Elkhorn, WI 53121

3. Plan Administrator and Named Fiduciary:

   Walworth County
   Human Resources Department
   100 W. Walworth Street
   Elkhorn, WI 53121
   262-741-7950

4. Plan Sponsor's Employer Identification Number (EIN): 39-6005752.

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.

6. Plan benefits described in this booklet are effective January 1, 2016.

7. The Plan year and fiscal year are January 1 through December 31.
   The Benefit Accumulation Period is January 1 through December 31.

8. Agent for service of legal process:

   Walworth County – County Clerk
   100 W. Walworth Street
   Elkhorn, WI 53121

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 paid for by the employer for full time employees. The employer will pay 50% of the monthly premium for 0.50 to 0.74 FTE employees. COBRA enrollees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.

11. Each employee participating in the Plan receives an electronic, and paper copy if requested, 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 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 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 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 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, visit Delta Dental's website at www.deltadentalwi.com or call 800-236-3712.

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit. The MPA will be reduced by any 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.

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 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: 92216

Effective Date of Program: January 1, 2016

Benefit Accumulation Period: A 12-month period of time over which maximums apply. The Benefit Accumulation Period is January 1 through December 31 (Calendar Year).

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 (Calendar Year):	$0.00
Per Family, per Benefit Accumulation Period (Calendar Year):	$0.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period (Calendar Year):	$1,200.00
Orthodontic Maximum Benefit per Person per Lifetime:	$1,500.00

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	**100%**	**100%**
Major Restorative Procedures I	**80%**	**80%**
Major Restorative Procedures II	**50%**	**50%**
Orthodontic Procedures	**50%**	**50%**

The program provides payment at the indicated percentage of fees, up to the maximum stated for each eligible person in each Benefit Accumulation Period (Calendar Year). A Benefit

Accumulation Period (Calendar Year) is a 12-month period of time over which maximums apply. The Benefit Accumulation Period (Calendar Year) 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.

Diagnostic and Preventive Procedures (100%)

1. Examinations twice in a benefit year.
2. Full mouth x-rays, which include bitewing x-rays, at 3-year intervals. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays twice in a benefit year, limited to a set of 4 films.
4. Dental prophylaxis (teeth cleaning) twice in a benefit year.
5. Topical fluoride applications twice per benefit year, for dependent children to age 19.
6. Space maintainers for retaining space when a primary tooth is prematurely lost.
7. Topical application of sealants for dependents through age 18. Application is limited to the occlusal surface of molars and bicuspids that are free of decay and restorations. Benefits are limited to 1 application per tooth per lifetime.

Basic Restorative Procedures (100%)

1. Emergency treatment to relieve pain.
2. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
3. Regular cavity fillings, including amalgam, synthetic porcelains, silicate, acrylic, plastic fillings, composite filling restorations of diseased or broken teeth and stainless steel restorations.
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 therapy).
6. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth) — nonsurgical treatment once each 2 years; surgical treatment once each 3 years. Periodontal maintenance – either periodontal maintenance or adult prophylaxis up to four in a benefit year.
7. Emergency denture repairs, reviewed on appeal.
8. Injections of antibiotic drugs by the attending dentist.

Major Restorative Procedures I (80%)

Crowns, inlays or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only

after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure as a benefit under this dental Plan.

Major Restorative Procedures II (50%)

Prosthetics, including fixed bridgework, partial dentures, and complete dentures to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing fixed bridge or partial/complete denture will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure under this dental Plan.

Fixed bridges and partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed procedure may be a benefit if no more than two teeth are missing in the dental arch in which the bridge is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch.

a. repairs and adjustments to prosthetic applies;
b. denture reline and rebase once in any 3-year period;
c. porcelain veneers on crowns or pontics on the six front teeth, bicuspids and upper first molars.

Dentures: Initial insertion of partial or full removable dentures (including any adjustments during the 6 month period following insertion), provided that:

a. For partial dentures: If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the cost of such procedure shall be made toward a more elaborate or precision appliance that a Plan Participant and Dentist may choose to use and the balance of the cost shall be the responsibility of the Plan Participant.
b. For complete dentures: If, in providing complete denture services, a Plan Participant and Dentist decide on personalized restorations or specialized techniques as opposed to standard procedures, payment shall be limited to the applicable percentage of the cost of the standard denture services, and the balance of the cost shall be the responsibility of the Plan Participant.

Bridge or denture replacement/modification: Replacement of an existing removable partial, full denture or fixed bridge by a new removable partial, full denture or a fixed bridge, or the addition of teeth to an existing removable partial or to a bridge, but only if satisfactory evidence is provided that:

a. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing removable partial or bridge was inserted; or,
b. The existing denture or bridge was inserted at least 5 years prior to its replacement and the existing denture or bridge cannot be made serviceable; or
c. The existing denture is an immediate temporary full denture which cannot be made permanent and replacement by a permanent denture takes place within 12 months from the date of initial insertion of the immediate temporary full denture.

Replacement of an existing denture shall be covered hereunder only if the existing denture is unserviceable and cannot be made serviceable; payment shall be limited to the applicable

percentage of the cost of services which are necessary to render such appliances serviceable; and replacement of prosthodontic appliances shall be covered hereunder only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

Double abutments: Covered only when dentally necessary.

Treatment partials: Covered only when used as a space maintainer for Plan Participant's under 19 years of age.

Orthodontic Procedures (50%)

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

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

Waiting Periods for Late Entrants

Plan Participants who were enrolled within the initial enrollment period are not subject to the waiting period limitations described in the next paragraph.

Benefits are available for a Late Entrant only after the Plan Participant has met the following Late Entrant waiting periods:

1. Diagnostic, preventive, ancillary, restorative -- after continuously covered under the plan for three consecutive months.
2. Oral surgery, endodontics, periodontics -- after continuously covered under the plan for one year.
3. Prosthodontics -- no coverage to replace those teeth lost or missing prior to the effective date. Covers replacement of teeth lost or missing on or after the effective date after continuously covered under the plan for one year.
4. Orthodontics -- after continuously covered under the plan for two consecutive years.

The full dental premium applies to Late Entrant coverage. There is no discount or reduced premium due to the special Late Entrant waiting periods.

Exclusions

This dental Plan does not provide coverage for the following:

1. Dental procedures provided or commenced prior to the effective date of your coverage under this dental Plan.
2. Dental procedures to treat injuries or conditions compensable under worker's compensation or employer's liability laws.
3. Dental procedures, including seating of appliances and prosthetics (crowns, bridges and dentures), that commenced prior to your effective date of coverage under this dental Plan.
4. 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.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. Cast restorations placed on eligible patients under age 12; prosthetics placed on eligible patients under age 16.
9. Appliances, restorations, or procedures 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; for implantology techniques; or for splints, unless necessary as a result of accidental injury.
10. Dental procedures provided by other than a licensed dentist or licensed hygienist employed by a dentist.
11. Dental procedures to treat injuries or diseases caused by riots or any form of civil disobedience; injuries sustained while committing a criminal act; injuries intentionally inflicted.
12. Claims not submitted to Delta Dental of Wisconsin within 12 months from the date the procedure was provided.
13. Dental Procedures in cases for which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Replacement of lost or stolen dentures or charges for duplicate dentures.
15. 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

Applicability

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

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

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

Definitions

The following definitions apply to this Coordination of Benefits provision:

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

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

Effects on the Benefits of This Plan

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

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

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

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

Eligibility

ELIGIBILITY: Individuals who belong to an **Eligible Class** are eligible for coverage under this Plan following the waiting period.

ELIGIBLE CLASS:

- All individuals who are employed by Walworth County in a qualifying position, a *County* Board Supervisor, or elected officers, subject to *County* Personnel Policy and/or any applicable collective bargaining agreement or *County* Ordinance.

EFFECTIVE DATE

Coverage under the Plan shall become effective on the date of the individual's eligibility provided he/she has made written application for such coverage on or before such date. The individual must apply for coverage within 31 days of eligibility for coverage to be effective on the date of eligibility. Please see the Enrollment section for all requirements for Timely Enrollment, Late Enrollment, Special Enrollment Periods, and Waiting Periods for Late entrants.

***DEPENDENT* ELIGIBILITY**

The following persons are eligible for Dependent coverage under this plan:

1. LAWFUL SPOUSE –A Plan Participant's lawful spouse in the state of residence, living in the same country, if not legally separated or divorced. The Plan Administrator may require documentation proving a legal marital relationship.

   Not considered eligible for spousal coverage:
   a) Common Law Spouses; and
   b) Same sex marriages/domestic partnerships

   If a divorce is pending, a Spouse cannot be dropped from coverage until the divorce is finalized. A finalized divorce decree must be submitted in order to drop Spouse's coverage from this Plan.

2. CHILDREN TO AGE 26 – A Plan Participant's Child up to age 26 is eligible for coverage through this plan regardless of marital status, employment status, or existence of other coverage. However, if the Child has coverage through their own employer or through their own spouse, then this coverage will pay all benefits as secondary to that coverage as outlined in the Coordination of Benefits section in this plan document. When the Child reaches limiting age, coverage will end on the last day of the Child's birthday month.

   MILITARY SERVICE EXTENSION (WISCONSIN STATE MANDATE): A child enrolled in this plan under this eligibility section who is under age 27 and who is called to federal active military service duty in the National Guard or a reserve component of the U.S. armed forces while the child was attending, on a full time basis, an institution of higher education, and such full time service call interrupts their eligibility for coverage under this plan past the date the child reaches age 26, will be eligible for coverage under this Plan for up to twelve months of coverage if over the limiting age, upon release/return from active service duty provided the child returns to school as a full-time student within 12 months of fulfilling the active duty obligation.

3. DEVELOPMENTALLY DISABLED OR PHYSICALLY HANDICAPPED CHILDREN – A Plan Participant's unmarried Dependent child who is incapable of self-sustaining employment by reason of Developmental Disability or physical handicap, primarily dependent upon the Plan Participant for support and maintenance and covered under this Plan when the child reaches the limiting age. Proof of physical or mental handicap must be submitted to the Plan Administrator within 31 days of the covered Dependent reaching the limiting age. Thereafter, proof may be required annually.

4. CHILDREN ENTITLED TO COVERAGE – as the result of one of the following:
   a) Qualified Medical Child Support Order (QMCSO);
   b) A National Medical Support Order;
   c) Divorce Decree; or
   d) Court Order.

The term "child" or "children" as referenced in the above sections includes:

a) An eligible Plan Participant's natural child;
b) An eligible Plan Participant's adopted child (from the date of placement);
c) An eligible Plan Participant's stepchild;
d) An eligible Plan Participant's grandchild until the Dependent child's parent is age 18;
e) Any other child for whom the eligible Plan Participant has legal guardianship or for a child for whom the eligible Plan Participant had noted legal guardianship on the child's 18^{th} birthday (proof is required).

An "adopted child (from the date of placement)" refers to a child whom the eligible Plan Participant has adopted or intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 on the date of such placement for adoption. The term placement means the assumption and retention by such eligible Plan Participant of a legal

obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by the Plan.

In any event, no person may be simultaneously covered as both an eligible Plan Participant and a Dependent. If both parents are eligible for coverage, only one may enroll for Dependent coverage. Certain exceptions may apply to this rule under collective bargaining agreements or County ordinances. See the Human Resources/Benefits Department for more information.

Excluded Dependents include: other individuals living in the covered eligible Plan Participant's home, but who are not eligible as defined; the legally separated or divorced former spouse of the eligible Plan Participant; any person who is on active duty in any military service of any country; or any individual who is eligible for coverage under this Plan as an eligible Plan Participant.

DEPENDENT **EFFECTIVE DATE**

A Dependent will be considered eligible for coverage on the date the eligible Plan Participant becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan. Each eligible Plan Participant who makes such written request for Dependent Coverage on a form approved by the Employer shall, become covered for Dependent Coverage as follows:

1. If the eligible Plan Participant makes such written request on or before the date he or she becomes eligible for Dependent Coverage, or within the time frame listed in "Eligible Plan Participant Eligibility" to enroll, the eligible Plan Participant shall become covered, with respect to those persons who are then his or her Dependents, on the date he or she becomes covered for Plan Participant coverage.

2. If the Dependent is a **Newborn** Child or newly **adopted** Child, then the Dependent is eligible for coverage from the date of the event (i.e., birth or date of placement). The newly-acquired Dependent must be enrolled and the Claims Administrator notified **within 60 days** of the date of the event. Benefits will not be paid until the Dependent is enrolled.

3. If a Dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new Dependent will be effective on the date of such court order, decree, or marriage if Dependent Coverage is in effect under the Plan at that time and proper enrollment is completed within 31 days of the event. If the eligible Plan Participant does not have Dependent Coverage in effect under the Plan at the time of the court order,

decree, or marriage and requests such coverage and properly enrolls this new Dependent within the 31 day period immediately following the date of the court order, decree, or marriage, then Dependent Coverage will be retroactive to the date of the court order, decree, or marriage.

TIMELY ENROLLMENT

The enrollment will be "timely" if the enrollment form is completed no later than 31-days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

LATE ENROLLMENT

Enrollment for coverage is required within 31 days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered Plan Participant's and/or Dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a Late Enrollee. Some late enrollments may be made under the following Special Enrollment provision; however, if the Special Enrollment provisions do not apply, the Late Enrollees will be effective the first of the month following the date the application was received in the Human Resources/Benefits Department. All Late Enrollees are subject to the waiting period. (See the Waiting Periods for Late Entrants Section)

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage, or for anyone who enrolls under a Special Enrollment Period, coverage is effective on the event date. Thus, the time between the date a Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Individuals losing other coverage (proof is required). An individual or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The individual or Dependent was covered under a group dental plan or had dental insurance coverage or coverage through a state Medicaid or Children's Health Insurance Program (CHIP) program, at the time coverage under this Plan was previously offered to the individual.

2. If required by the Plan Administrator, the individual stated in writing at the time that coverage was offered that the other dental coverage was the reason for declining enrollment.

3. The coverage of the individual or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and:

a. the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment or other cancellation by the Medicaid or CHIP program providing coverage); or
b. Employer contributions towards the coverage were terminated; or
c. the Plan Participant reaches or exceeds the Plan Year Maximum Benefit within the plan.

4. The individual or Dependent requests enrollment in this Plan no later than 31-days after the date of exhaustion of COBRA coverage or the termination of coverage or Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

5. If the loss of coverage was through a Medicaid or CHIP program, the individual or Dependent requests enrollment in this Plan no later than 60-days after the date of exhaustion or cancellation by the Medicaid or CHIP program. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the individual or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

Dependent **beneficiaries** if:

1. The individual is a Plan Participant under this Plan (or has met the Waiting Period applicable to becoming a Plan Participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

2. A person becomes a Dependent of the individual through marriage, birth, adoption or placement for adoption: or

3. The Dependent was previously covered through a Medicaid or CHIP program, and has lost eligibility for coverage through said program,

then the Dependent (and if not otherwise enrolled, the individual) may be enrolled under this Plan as a covered Dependent of the covered Plan Participant. In the case of the birth or adoption of a child, the spouse of the covered Plan Participant may be enrolled as a Dependent of the covered Plan Participant if the spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31-days and begins on the date of the marriage, birth, adoption or placement for adoption. If the reason for enrollment is loss of coverage through a Medicaid or CHIP program, the Special Enrollment Period is a period of 60-days and begins on the date of loss of coverage through that plan.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

1. in the case of marriage, the date of marriage;

2. in the case of a Dependent's birth, as of the date of birth;

3. in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or

4. in the case of a loss of coverage through Medicaid or CHIP, the date of the loss of said coverage.

WAITING PERIODS FOR LATE ENTRANTS

Plan Participants who were enrolled within the initial enrollment period are not subject to the waiting period limitations described in the next paragraph.

Benefits are available for a Late Entrant only after the Plan Participant has met the following Late Entrant waiting periods:

1. Diagnostic, preventive, ancillary, restorative -- after continuously covered under the plan for three (3) consecutive months.

2. Oral surgery, endodontics, periodontics -- after continuously covered under the plan for one (1) year.

3. Prosthodontics -- no coverage to replace those teeth lost or missing prior to the effective date. Covers replacement of teeth lost or missing on or after the effective date after continuously covered under the plan for one (1) year.

4. Orthodontics -- after continuously covered under the plan for two (2) consecutive years.

The full dental premium applies to Late Entrant coverage. There is no discount or reduced premium due to the special Late Entrant waiting periods.

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 day you or your dependents are no longer eligible or the day this dental Plan is terminated.

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.

Uniformed Services Employment and Reemployment Rights Act

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

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 Coverage

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

For the Subscriber:

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

For Covered Dependents

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

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

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

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

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

result of the same Qualifying Event unless otherwise specified in the election or the covered beneficiary independently elects COBRA continuation coverage.

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

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

The first premium must be paid to the group within 45 days of the election of COBRA continuation coverage and payment must include all premiums from the effective date of COBRA continuation coverage. Future premium payments must be paid by the first day of each month.

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

Rights of Recovery (Subrogation)

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

Date: 12/07/2015

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 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;
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