CITY OF DE PERE

Employee Certificate

CARE-PLUS Dental Plans, Inc.

CERTIFICATE OF INSURANCE

under

CITY OF DE PERE
Group No. PPD281
Issued by

CARE-PLUS Dental Plans, Inc.

PLAN ADMINISTRATOR: **City of De Pere**
335 S. Broadway Street
De Pere, WI 54115

EMPLOYER I.D. #: **39-6005431**

EFFECTIVE DATE: **January 1, 2016**

This certifies that CARE-PLUS Dental Plans, Inc. has issued and delivered to the Policyholder a Group Contract insuring certain Participants covered by the Contract. Certain provisions of the Group Contract are summarized in the Plan Benefit Schedule Addendum "A" and the Procedures Description Addendum "B", which are attached hereto and made a part of this certificate.

This individual certificate is furnished in accordance with and is subject to the terms of the Group Contract. An individual is covered under the policy only if the terms, provisions and conditions of the policy have been satisfied. The coverage described in the policy is available to a person and his or her dependents only if the person is eligible, has enrolled for coverage and the proper fees have been paid by the Policyholder.

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Rd., Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
(800) 318-7007

CARE-PLUS SMILE ADVANTAGE DENTAL PROGRAM

PLAN BENEFIT SUMMARY

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OFFICES

DENTAL ASSOCIATES, LTD. OF WISCONSIN has offices at multiple locations. See the Dental Associates website (www.dentalassociates.com) for a complete listing.

CARE-PLUS DENTAL PLANS, INC.
DENTAL CARE GROUP POLICY

INTRODUCTION

Welcome to the "CARE-PLUS Smile Advantage" program. CARE-PLUS Dental Plans, Inc. ("CARE-PLUS") is a non-profit insurance company. CARE-PLUS was formed in 1983 to provide comprehensive dental care programs. CARE-PLUS is a managed care group dental insurance plan developed jointly by CARE-PLUS and Dental Associates, Ltd. of Wisconsin to provide both general and specialty dental care.

Members of CARE-PLUS Smile Advantage receive their care from Dental Associates, Ltd. of Wisconsin, one of the largest group practices in Wisconsin. The Dental Associates staff believes in establishing a positive doctor-patient relationship. This relationship is the cornerstone for a long-term program that emphasizes preventive care and early detection of problems. CARE-PLUS Smile Advantage is designed to encourage You to visit the dentist regularly.

Please take a few minutes to read through this Certificate so You may get a thorough understanding of Your Benefits and CARE-PLUS' policies and procedures.

This Certificate briefly summarizes the insurance Contract between CARE-PLUS and Your Group. The Master Group Contract governs the Benefits and limitations of Your coverage. You may review the Contract during normal business hours if You desire. Please call Your Group or CARE-PLUS.

QUALITY IMPROVEMENT
Summary

CARE-PLUS has established a quality improvement committee that identifies, evaluates and seeks to improve processes related to access to care and quality of care.

Through a series of project and process management activities, all staff members are involved with the implementation of our quality improvement initiatives. Additionally, Members play a vital role in improving the quality of care. Please bring any problems or complaints to our attention immediately.

RIGHTS AND RESPONSIBILITIES OF PARTICIPANTS

Participant Rights

Right To Choose
You have the right to choose the clinic from which You will receive services from among Dental Associates, Ltd's network of clinics.

Right To Information
You have the right to information on Your dental plan relating to:

- Covered and excluded dental Benefits
- Available general and specialty care providers
- Preventive care
- Your condition and its related care
- The process to make known a complaint or request, and
- Policies and procedures relevant to Your care.

Right To Privacy and Confidentiality
You have the right to privacy and confidentiality of all communications and records on Your care.

Right To Be Treated with Respect and Dignity
You have the right to be treated with respect and dignity regardless of Your race, age, sex or creed.

Right To Participate in Your Care
You have the right to be active in decisions about Your treatment. You have the right to a candid discussion of appropriate or dentally necessary treatment options for Your condition, regardless of cost or benefit coverage. You have the right to be informed about the risks and benefits of treatment and to refuse care.

Right To Present a Complaint or Grievance
You have the right to voice concerns about Your care and to receive a prompt and fair review of Your complaints. You have the right to courteous and attentive treatment.

Participant Responsibilities

You Must Know Your Benefits and Requirements
You have a responsibility to:

- Understand Your dental plan Benefits,
- Follow the required procedures, and
- Ask questions about things You do not understand.

You Must Provide Accurate Information
You have a responsibility to provide accurate and complete information about Your health and dental history and Your eligibility and enrollment. You have a responsibility to fulfill any financial obligations You may incur on the day You receive services.

You Should Participate in Your Care
You have a responsibility to participate in Your care by:

- Asking questions to understand Your condition,
- Following the recommended or agreed upon, treatment plan for Your condition, and
- Making healthy lifestyle choices to try to maintain Your oral health and prevent illness.

You Must Keep Your Appointments
You have a responsibility to keep Your appointments or to give early notice if You must reschedule or cancel an appointment or it will be considered a missed appointment. A surgical appointment is considered "missed" if You do not show up or if You cancel with less than forty-eight (48) hours notice. All other appointments require twenty-four (24) hours notice of cancellation.

You Must Show Consideration and Respect
You have a responsibility to show consideration and respect to health care providers and staff.

DEFINITIONS

When used and capitalized in this Certificate or any amendments or riders attached hereto, the terms listed below are defined as follows:

1. **Benefits**. Under the Contract, Benefits include the Dental Service and Emergency Service as described in the Plan Benefit Schedule.

2. **CARE-PLUS Dental Plans, Inc**. CARE-PLUS Dental Plans, Inc. is a Wisconsin corporation located in Milwaukee, Wisconsin. It will be referred to as CARE-PLUS in this Certificate.

3. **Charge**. A Charge is the usual, customary, and reasonable fee or cost for a Dental Service. Fees are usual, customary and reasonable if they do not exceed the cost usually charged by the individual rendering the service or the general level of fees for similar services charged by others within the community where rendered, taking into consideration the complexity of treatment required for the particular case. No agreement as to the fee between You and a person, firm or corporation providing or rendering services shall increase the liability of CARE-PLUS to pay more than the usual, customary, and reasonable fee.

4. **Contract**. The Contract is the agreement by CARE-PLUS to provide Benefits to the Group and includes the application You submitted to the Group and any supplements, amendments, endorsements or riders attached to the Contract.

5. **Dental Service**. Dental Service means those professional services of a Group Dentist that are generally and customarily prescribed except as expressly limited or excluded by the Contract.

6. **Dentist**. A Dentist is someone who is licensed as a Doctor of Dental Surgery or its equivalent and who is a professional practitioner authorized by law to practice dentistry.

7. **Effective Date**. Your Effective Date is the date on which You become covered for Benefits.

8. **Emergency**. A serious dental condition caused by dental disease or accident that arises suddenly. If not treated immediately, an Emergency would result in jeopardy to Your dental health.

9. **Emergency Service**. The services described as Emergency Service in the Plan Benefit Schedule.

10. **Grievance**. Any dissatisfaction with CARE-PLUS, a Primary Provider, the administration, claims practice or services provided under the Contract, expressed in writing by You or on Your behalf.

11. **Group**. The Group is the Employer through which You have this coverage.

12. **Group Dentist**. A Group Dentist means a Dentist who is employed by, associated with or engaged by Dental Associates, Ltd. of Wisconsin.

13. **Laboratory Charges**. Laboratory Charges are any charges incurred by a Group Dentist or charged to the Group Dentist by a dental laboratory. Laboratory Charges are charged for the preparation and

fabrication of space maintainers, all indirect restorations, prosthetic appliances, or the repair of the above.

14. **Member**. A Member is an employee (whether single or married) of the Group who is reported as eligible for Benefits under the Contract and for whom the proper fees have been paid.

15. **Out of Area Services**. Services rendered at a location outside the Service Area.

16. **Participant**. A Participant means any Member or his or her Dependents.

17. **Primary Provider**. Under the Contract, a Primary Provider is any provider selected by CARE-PLUS. Dental Associates, Ltd. of Wisconsin is currently the Primary Provider of Benefits for the Contract. Dental Associates has offices at the locations specified on the Plan Benefit Schedule.

18. **Service Area**. The geographic area within a 50-mile radius of a Primary Provider location.

19. **You**. The Member and his or her enrolled Dependents, unless specifically stated that "You" refers only to a Member or Dependent.

ELIGIBILITY

AN ELIGIBLE MEMBER:
is an employee (whether single or married) of the Group who is reported by the Group as eligible for Benefits under the Contract.

A FAMILY DEPENDENT IS:
1. The Member's legal spouse.

2. The Member's children, including stepchildren, legally adopted children, and children placed for adoption with the Member, for whom the proper fees have been paid. A child placed for adoption shall be covered even if a court does not make a final order granting adoption; however, coverage will terminate if the child's adoptive placement with the Member terminates.

   A child ceases to be a Dependent on the last day of the month in which he or she attains the age of 26.

   In addition, if a child is unmarried and is 18 years of age and older and was a full-time student under the age of 27 at the time they were called to active duty in the reserves or national guard, they will remain an eligible Dependent under the parent’s plan beyond the age of 27 until they are no longer a full-time student.

   A child continues to be an eligible Dependent beyond the limiting age above if he or she is unable to support himself or herself due to mental retardation or physical handicap. You must send CARE-PLUS a Doctor's certification of disability at least 31 days before the child reaches the limiting age and as often as CARE-PLUS requests for the following 2 years. After that, CARE-PLUS will request proof of disability annually.

3. Any child of a Dependent child (the Member's grandchild) until the Dependent child reaches the age of 18.

4. The Member's children pursuant to a qualified medical child support order.

ENROLLMENT

INITIAL ENROLLMENT PERIOD: At the time the Group is initially enrolled, each Member shall complete a CARE-PLUS application form. The Effective Date for Members enrolled during the initial enrollment period is the date the Contract begins.

SUBSEQUENT ENROLLMENT PERIOD: Employees not participating under the Contract may enroll or existing Members may terminate their coverage only during a subsequent enrollment period.

NEW EMPLOYEES: New employees of the Group and their Dependents may enroll within thirty-one (31) days of the date the employee first becomes eligible for coverage. If the employee properly enrolls and the required premium is paid, the Effective Date for new employees and their Dependents is the first of the month following the date of eligibility. If the new employee declines coverage, (s)he may enroll at the next open enrollment period except in the case of an event that permits earlier enrollment. An employee who declines coverage because (s)he was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The employee must apply for such change in coverage within thirty-one (31) days of the event causing the loss of the other coverage.

NEW DEPENDENTS:

1. MARRIAGE. Dependents who become eligible due to marriage may enroll within thirty-one (31) days of the marriage date. If such Dependents are properly enrolled and the applicable premium is paid within such timeframe, the Effective Date for such Dependents is the date of the marriage.
2. NEWBORN CHILDREN. A Member's newborn child will be covered from the date of birth provided CARE-PLUS is notified of the birth and the Member pays the additional premium within sixty (60) days of the date of birth. Otherwise, the child may be enrolled within one year after the date of birth if the Member makes all past due payments of the applicable Premium.

   If no additional premium is required to enroll the child, the newborn child will be covered as of the date of birth. CARE-PLUS requests that the Member notify CARE-PLUS within sixty (60) days of the birth of the new Dependent.
3. ADOPTED CHILDREN. An adopted child or child placed with the Member for purposes of adoption will be covered from the date of the final decree of adoption or date of placement if any required premium is paid and the Plan is notified within sixty (60) days after the date of adoption or placement.

IDENTIFICATION CARDS: Initial and subsequent Members will receive a CARE-PLUS identification card.

CHANGES IN MEMBERSHIP STATUS. You should notify Your Group as soon as possible of any change of address or in Your membership status resulting from marriage, divorce, separation, death, birth or the adoption of a child.

APPOINTMENTS: Each Member, including Dependents, must select a primary dental center. For convenience or doctor preference, all family members are not required to select the same center. If You desire to be treated at one center and a member of Your family prefers another center, simply contact CARE-PLUS and we will make the arrangements.

You are eligible to receive treatment as of Your Effective Date. To schedule an appointment, please call the number assigned to the center of Your choice.

With CARE-PLUS Smile Advantage, You also have the right to change Your Group Dentist or dental center at any time, for whatever reason.

BROKEN APPOINTMENTS

If You break an appointment without at least forty-eight (48) hours notice for a surgical appointment or twenty-four (24) hours notice for all other appointments, the Dentist may charge a fee for the block of time reserved. This fee is not covered under the Contract.

BENEFITS

The Benefits available to You are the Dental Services and Emergency Service set forth in the attached Benefit Schedule and Procedure Description.

EXCLUSIONS AND LIMITATIONS

Benefits shall not include:

1. Dental Services not specifically described in the Contract as a Benefit.
2. Dental Services with respect to congenital malformations or that are primarily for cosmetic or esthetic purposes, except congenitally missing teeth.
3. Any duplicate prosthetic device or any other duplicate appliance, except as otherwise provided.
4. The replacement of a lost or stolen prosthetic device or appliance, except as otherwise provided.
5. The replacement of an orthodontic appliance, except as otherwise provided.
6. Treatment of temporomandibular joint (TMJ) dysfunction.
7. Gold foil, gold or precious metal restorations, except when used as necessary functional material.
8. Transplants.
9. Dental Service or Emergency Service:
   (a) That would be furnished, without charge, to You by any person or entity other than CARE-PLUS;
   (b) That You would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government;
   (c) That You are entitled or would be entitled if You were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if the Contract were not in effect;

(d) To the extent that Medicare is Your primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no Benefits are available to the extent You would have been entitled to Medicare benefits had You enrolled in Medicare or complied with Medicare requirements.

(e) For, or resulting from injuries, disease or conditions for which You receive, or are the subject of, any award or settlement under a Workers Compensation Act or any Employer Liability Law; or

(f) Rendered or furnished after the date You cease to be covered under the Contract, unless your cessation of coverage is not due to a termination of the Contract, in which case coverage may continue for You until the earlier of the date You are covered by an alternative dental policy or the date the Contract is no longer in force. Continued coverage is only available for:

(i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and

(ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following, termination of coverage.

(g) Provided at a location other than the offices of the Primary Provider except for Emergency Service.

10. Hospital or physician services of any kind whether or not related to covered Dental Services.

11. Dental Service and Emergency Service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of this Contract and caused by atomic explosion whether or not the result of war.

12. Reimbursement to the Participant or any dental office for the cost of Dental Services provided by Dentists other than the Primary Provider, unless expressly authorized in writing by the Primary Provider or due to an Emergency.

13. Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit shown in the Benefit Schedule.

14. Dental Service and Emergency Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.

15. Replacement of an existing removable denture, full denture, crown or fixed bridge by a new removable partial denture, full denture, crown or a fixed bridge if the existing appliance was provided in the previous five years. The five-year period will be measured from the date on which the existing appliance was last supplied, whether under the Contract or under any other dental coverage.

16. If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the Participant selects a more complicated treatment (precision attachments or fixed bridgework), Benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the Participant.

17. Services or supplies for personalization or characterization of dentures or bridges.

18. Crowns to restore diseased or broken teeth when the tooth can be restored by a conventional type filling.

19. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

    (a) Benefits are provided or payable under any Workers' Compensation, Employer Liability Law, or Occupational Disease Act or Law; or

    (b) You would have been eligible for benefits under any Workers' Compensation, Employer Liability Law or Occupational Disease Act or Law had You applied for such coverage;

20. Any service related to:

    (a) Altering vertical dimension;

    (b) Restoration of occlusion;

    (c) Splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth;

    (d) Replacing tooth structures as a result of abrasions, attrition, or erosion; or

    (e) Bite registration or bite analysis.

21. Missed appointment charges.

22. Removal of asymptomatic third molars (wisdom teeth).

23. Procedures done in conjunction with fixed complex implant retainer prosthetics.

TERMINATION

1. **Termination by Group**. If the Contract terminates for any reason, Your rights to Benefits under the Contract shall terminate immediately.

2. **Termination of Member**. Your rights to Benefits under the Contract shall terminate at the end of the period for which the Group paid the last Fee Deposit to CARE-PLUS.

3. **Termination of Dependent**. A Dependent's rights to Benefits under the Contract shall automatically cease at the end of the month in which he ceased to be a Dependent or at the end of the period for which the last Fee Deposit was paid to CARE-PLUS by the Group, if earlier.

5. **Service After Termination**. Except as otherwise provided in the Contract, in the event any services are required by You or are performed on Your behalf after Your rights to Benefits have terminated, the expenses incurred for such care shall be Your full responsibility.

CONTINUATION OF COVERAGE

Federal law ("COBRA") allows You to continue coverage beyond the date coverage normally ends. The Contract complies with COBRA to the extent required by law.

The Group must determine whether COBRA applies to it. The Group must comply with COBRA requirements for employers and plan administrators.

You may elect COBRA if you are a Qualified Beneficiary and you lose coverage under this Plan due to a Qualifying Event. Your summary plan description contains a detailed description of the terms and conditions of COBRA coverage.

MEDICARE

Members aged 65 or older should go to their Personnel Office for a description of insurance options available to them.

Participants should go to the nearest area office of the Social Security Administration to enroll in Medicare three months before their 65th birthday, or if their doctor certifies they are disabled. Failure to enroll in Medicare may reduce the Benefits under the Contract. Please see the "Exclusions and Limitations" article.

DISENROLLMENT

CARE-PLUS may disenroll You, resulting in termination of coverage, for any one of the reasons described below:

1. You fail to pay required premiums within 31 days after the due date.

2. You permit someone else to use the enrollment identification or knowingly provide fraudulent information in applying for coverage or receiving services.

3. You pose a threat to providers or other Members of the plan because of physical or verbal abuse.

4. You are unable to establish or maintain a satisfactory provider-patient relationship with a Primary Provider. Disenrollment only will occur after CARE-PLUS has provided You with an opportunity to select an alternate provider, has made reasonable efforts to assist You in establishing a satisfactory provider-patient relationship, and has provided You with notice of the right to file a Grievance.

5. You move outside the Service Area.

If You are disenrolled, You may appeal CARE-PLUS' decision by filing a Grievance. CARE-PLUS will arrange alternative dental coverage for You if You are disenrolled until the earlier of: (a) the date You find alternative coverage, or (b) the date You have an opportunity to change plans.

CLAIM RULES

1. **Definitions**.

   "Pre-service claim" is a claim for which approval is required before receipt of care.

   "Urgent care claim" is a claim where waiting the standard time for a benefit decision could seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of a physician with knowledge of Your condition, would subject You to severe pain that cannot be adequately managed without the care requested.

   "Post-service claim" is a claim for payment or reimbursement after receipt of care.

2. **Proof of Loss.** You must give us written proof of a loss with a claim. This proof must cover the occurrence, character and extent of the loss. You must furnish proof within ninety (90) days after the date of the loss. Claims furnished after ninety (90) days will not be considered valid. However, if it is not reasonably possible to meet such time limit, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

   If You fail to properly follow our procedure for filing a pre-service claim, we will notify You within five (5) days of the proper procedure. If the claim is an urgent care claim, we will notify You within twenty-four (24) hours.

3. **Initial Determinations.**

   a. Urgent Care Claims.

      If Your claim is an urgent care claim, we will provide You with a decision as soon as possible, taking into account Your medical circumstances. We will make a decision no later than seventy-two (72) hours after receipt of Your claim. However, if we require additional information from You to make the benefit determination, we will make such a request within twenty-four (24) hours of receipt of Your claim. You will have a reasonable amount of time to provide the information taking into account Your medical circumstances. Reasonable means not less than forty-eight (48) hours. We will reach a decision as soon as possible, but not later than forty-eight (48) hours from:

      (1) The receipt of the additional information from You, or

      (2) The end of the time period You had to provide the information

      whichever occurs first. If we orally deny Your claim, You will receive a written notice within three (3) days. Our denial will include all the elements listed in part d.

   b. Concurrent Care Decisions.

      We may approve an ongoing course of treatment to be provided over a period of time or a number of treatments.

      If we have approved an ongoing course of treatment and we determine that such treatment should be reduced or terminated before the end of the period of time or number of treatments authorized, we will inform You enough time in advance of the reduction or termination to appeal our decision before we reduce or terminate such treatment. The notice will include all the

elements listed in part d. If Your appeal to continue treatment is an urgent care claim, we will make a determination as soon as possible, taking into account Your medical circumstances. We will make a decision no later than twenty-four (24) hours after receipt of Your appeal.

c. Other Claims.

All other initial determinations will be made within the following timeframes:

(1) Pre-service claims: Within a reasonable amount of time appropriate to the medical circumstances but not later than fifteen (15) days after the date the claim was received by us.

(2) Post-service claims: Within a reasonable period of time, but not later than thirty (30) days after the date the claim was received by us.

If we determine that we will not be able to meet the above deadline, for reasons beyond our control, we will notify You in writing prior to the expiration of the initial deadline. The notice will state the reason for the delay and the date on which You can expect a decision. The expected decision date will not be more than fifteen (15) days from the original deadline. However, if we require additional information from You to make the benefit determination, the expected decision date will be not more than fifteen (15) days from the date You respond to the request for additional information. The notice will specifically describe the additional information required. You will have forty-five (45) days from the date You receive the notice to provide the additional information.

d. Claim Denials.

If we deny Your claim, in whole or in part, we will inform You in writing. The denial notice will include all of the following:

(1) The specific reason(s) for the denial.

(2) Reference to the specific plan provision on which the denial is based.

(3) A description of any additional information needed to complete the claim and an explanation of why the information is necessary.

(4) A description of Your right to appeal, including the deadline and procedures, and Your right to bring a civil action under the Employee Retirement Security Income Act of 1974, as amended, ("ERISA") section 502(a) if the appeal is not decided in Your favor.

(5) If we used a specific internal guideline to make our determination, a statement that we relied on such guideline and that You may obtain a copy of the guideline free of charge, upon request.

(6) If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

(7) If Your claim involves urgent care, a description of our expedited review process.

e. Appeal of Claim Denials. You have one hundred eighty (180) days after You receive a notice described in part d above to appeal a claim denial. You appeal a claim denial by following the Grievance Procedure explained below.

4. **Grievance Procedure.**

You will be notified of Your right to file a Grievance and the procedure to follow each time a claim or benefit is denied. This includes a refusal to refer You for additional services, or when disenrollment proceedings are initiated. The notification will state the specific reason for the denial or initiation of disenrollment proceedings. The Grievance procedure is outlined below.

In the event that You have a complaint or problem regarding services under the Contract, You should submit Your Grievance in written form to CARE-PLUS' Grievance committee. The Grievance committee will acknowledge the Grievance in writing within five (5) business days of receipt.

If Your Grievance is an appeal of an urgent care claim, You may request an expedited Grievance. You should call 1-414-771-1711 or 1-800-318-7007 and state that You would like an expedited Grievance.

You have the following rights with respect to Your Grievance:

a. The right to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

b. The right to submit written comments, documents, records and other information relating to Your claim.

c. The right to appear before the Grievance committee to present written or oral information and to question the person who made the initial determination that resulted in the Grievance. The Grievance committee shall notify You of the date and time of the committee meeting at least seven (7) calendar days before the meeting is scheduled.

The Grievance committee will conduct a complete, new review of Your claim, without considering the initial determination. The committee will not include the person who originally denied the claim or that person's subordinate. If the claim requires a medical judgment, the committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. If a health care professional was consulted in making the initial determination, the health care professional consulted on appeal will not be the same person or that person's subordinate. Upon request, we will provide You with the names of the medical or vocational experts consulted to reach a determination.

The Grievance committee will provide You with a written decision within the following timeframes:

a. Urgent care claim: As quickly as Your condition requires, but no later than within seventy-two (72) hours of receipt of the Grievance.

b. Pre-service claim: Within thirty (30) days of the date we originally received the Grievance.

c. Post-service claim: Within thirty (30) days of the date we originally received the Grievance.

The committee's written decision will notify You of the result of Your Grievance and any corrective action taken. The decision will be signed by a member of the committee and include the position titles of the committee members.

If the Grievance committee denies Your appeal, in whole or in part, the written decision will include all of the following:

a. The specific reason(s) for the denial.

b. Reference to the specific plan provision on which the denial is based.

c. A statement that You are entitled to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

d. A statement of Your right to bring a civil action under ERISA section 502(a).

e. If the Grievance committee used a specific internal guideline to make the determination, a statement that it relied on such guideline and that You may obtain a copy of such guideline free of charge, upon request.

f. If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

You may resolve the Grievance by taking the steps outlined above. You also may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the **Office of the Commissioner of Insurance** by writing to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Or You can call 1-800-236-8517 outside of Madison or 1-608-266-0103 in Madison, and request a complaint form.

5. **Authorized Representative.**

Your authorized representative may act on Your behalf in pursuing a claim or Grievance. Unless one of the exceptions listed below applies, You must submit a statement in writing that the representative is authorized to act on Your behalf and may receive Your confidential information. We have a form available that You may use to appoint an individual as Your authorized representative.

We will not require written authorization if any of the following applies:

a. The person is authorized by law to act on Your behalf.

b. You are unable to give consent and the person is a spouse, family member or the treating provider.

c. The Grievance is an expedited Grievance and the person represents that You have verbally authorized the person to represent You.

GENERAL CONDITIONS

1. **Dentist/Participant Relationship**. Nothing in the Contract shall interfere with the professional relationship between You and Your attending Dentist.

2. **Evidence of Participation**. You must present Your identification card, or otherwise make the fact of Your participation known, to the Group Dentist when applying for Benefits.

3. **Release of Information**. You expressly consent to, authorize and direct any Dentist or other person or corporation by whom or in which dental, medical or surgical treatment is being considered or has been rendered, to release any records or other information, or copies thereof, as CARE-PLUS may request.

4. **Subrogation**. Whenever CARE-PLUS has been or is providing Benefits because of an injury or sickness for which a third party may be liable, CARE-PLUS may make a claim or maintain an action against the third party for damages, reimbursement or payment to the extent of the value of Benefits received or to be received.

   By accepting Benefits from CARE-PLUS relating to an injury or sickness, You assign to CARE-PLUS the right to make a claim against the third party to the extent of the value of Benefits rendered.

   You and CARE-PLUS agree to join the other in making a claim against the third party or commencing an action.

   To the extent required by law, CARE-PLUS shall seek to recover proceeds from You only after You have been wholly or fully compensated for the damages arising from the injury or sickness. CARE-PLUS shall have an equitable lien that shall attach to any recovery to the extent of its subrogation rights. You shall hold in trust for CARE-PLUS any proceeds recovered to the extent of its subrogation rights.

   You must not do anything after the loss to prejudice any rights of CARE-PLUS or of the Group to recovery. You must promptly advise CARE-PLUS and the Group in writing whenever a claim against a third party is made with respect to any loss for which Benefits were, or are being, received from CARE-PLUS.

   Nothing contained in this section shall limit the ability or right of the Group to make a claim or maintain an action against the third party for recovery.

5. **Monetary Value of Benefits**. When it is necessary to determine the monetary value of Benefits provided to You under the Contract, such value shall be the charges that would have been made if the Contract were not in effect.

6. **Non-Assignment of Benefits**. No person other than You is entitled to Benefits under this Contract. Rights under this Contract are not assignable or transferable in any manner. Rights shall be forfeited if You or any other person assigns, transfers or aids any other person improperly in obtaining Benefits hereunder.

7. **Limitation of Actions**. You may not start an action or suit, at law or in equity, to recover Benefits under the Contract until at least sixty (60) days after a claim has been filed with CARE-PLUS in writing or CARE-PLUS denies the claim, whichever is earlier. No action shall be commenced more than three years from the time the written proof of loss is required to be furnished to CARE-PLUS.

8. **Obligation of CARE-PLUS**. CARE-PLUS shall in no way be responsible for any act or omission of any Primary Provider, Group Dentist, professional practitioner or their agents, to supply Dental Services. The obligation of CARE-PLUS shall be limited solely to providing Benefits according to the provisions in the Contract.

9. **Reimbursement**. You agree to reimburse CARE-PLUS for any Benefits paid or provided for which You were not eligible under the terms of the Contract. Such reimbursement shall be due and payable immediately upon notification and demand to You by CARE-PLUS.

10. **Misrepresentations**. Fraudulent misstatements by You shall void Your coverage and serve as the basis for denials of claims for Benefits.

11. **Dual Coverage**. If You are eligible for Benefits under more than one CARE-PLUS Contract, You shall be entitled to an allowance therefore equal to the Charges for the aggregate Benefits available under such CARE-PLUS Contracts, up to, but not exceeding, the total incurred regular Charges for all Dental Services.

COORDINATION OF BENEFITS

1. APPLICABILITY. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan. However, this provision may be superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

   If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

   a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. 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."

2. DEFINITIONS.

   a. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care. Allowable Expense includes Dental Services and Orthodontic Services, when the item of expense is covered at least in part by one or more Plans covering the claimant. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

   b. "Claim Determination Period" means a Calendar Year. However, 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.

   c. "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. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-

governmental program. Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

d. "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 This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

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.

e. "This Plan" means the part of the Group Contract that provides Benefits for Dental Service expenses.

3. ORDER OF BENEFIT DETERMINATION. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its Benefits determined after those of the other Plan, unless:

a. The other Plan has rules coordinating its benefits with those of This Plan; and

b. Both those rules and This Plan's rules described below require that This Plan's Benefits be determined before those of the other Plan.

4. RULES. This Plan determines its order of benefits using the first of the following rules that applies:

a. Non-dependent/Dependent. The benefits of the Plan that covers the person other than as a Dependent are determined before those of the Plan that covers the person as a Dependent.

b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph c., when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

(1) 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 that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (1) 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.

c. 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:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) 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 health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule b. above.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the 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.

d. Active/Inactive Employee. The benefits of a Plan that 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 that 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 d. is ignored.

e. Continuation Coverage. 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 person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

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

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. 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 that covered that person for the shorter time.

5. EFFECT ON THE BENEFITS OF THIS PLAN.

a. When This Section Applies. This Section applies when, in accordance with the Section "Order of Benefit Determination", This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

b. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(1) The Benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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.

6. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. CARE-PLUS has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming Benefits under This Plan must give CARE-PLUS any facts it needs to pay the claim.

7. FACILITY OF PAYMENT. A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, CARE-PLUS may pay that amount to the organization that made that payment. That amount will then be treated as though it was a Benefit paid under This Plan. CARE-PLUS 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.

8. RIGHT OF RECOVERY. If the amount of the payments made by CARE-PLUS is more than it should have paid under this COB provision, it may recover the excess from one or more of:

   a. The persons it has paid or for whom it has paid;

   b. Insurance companies; or

   c. Other organizations.

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

For further information, contact:

CARE-PLUS Dental Plans, Inc.
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Wauwatosa, Wisconsin 53222
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ADDENDUM A
PLAN BENEFIT SCHEDULE
FOR
CITY OF DE PERE
GROUP NO. PPD281

1. COVERED DENTAL SERVICES. Except as otherwise specified in this Contract, Participants are entitled to any of the Dental Services listed that begin on or after their Effective Date of coverage. Such Dental Services are to be consistent with and necessary, according to accepted standards of good dental practice, for the diagnosis and treatment of the Participant and must not be performed primarily for cosmetic purposes.

2. ANNUAL MAXIMUM BENEFITS. The Annual Maximum Benefit for Dental Services, except orthodontic services, is

   a. $2,000.00 per eligible Participant;

3. ORTHODONTIC SERVICES. Benefits for a complete routine orthodontic case shall:

   a. Be available to eligible Participants to include adults;

   b. Be subject to a copayment of 50% of the Group Dentist's fees to be paid by the Participant; and

   c. Be subject to a lifetime maximum benefit of $2,000.00.

   A routine orthodontic case is one in which alignment of the teeth is accomplished using a single phase of treatment with complete braces and a single set of retainers. Additional costs are incurred when treatment requires auxiliary fixed or removable appliance therapy, such as the use of functional jaw orthopedic appliances; treatment of impacted teeth/tooth; cleft palate; orthognathic surgery procedures; or use of ceramic braces or other specialized braces other than stainless steel that the patient may require or request for specific reasons.

   Each Participant eligible under a. shall be entitled to one complete course of orthodontic treatment while the Contract is in force.

   Orthodontic Benefits including surgical and appliance therapy will only be provided when, in the opinion of the orthodontist, treatment is necessary, and a satisfactory result can be achieved.

   Orthodontic benefits will terminate when a Participant ceases to be eligible for coverage, i.e. age limitations for orthodontic treatment or termination of the Contract by the Group or CARE-PLUS for any reason.

   Cross bite in permanent teeth will only be treated when, in the opinion of the orthodontist, other conditions are present that would indicate that orthodontic treatment is necessary.

   If the orthodontic treatment is terminated for any reason before completion, the obligation of CARE-PLUS to provide Benefits shall cease as of such date of termination. If such orthodontic treatment is resumed, Benefits shall resume, to the extent remaining under this Contract.

4. LABORATORY CHARGES. Except as otherwise provided, the Participant will not be liable for Laboratory Charges.

5. EMERGENCY SERVICE. Emergency Service includes Dental Service that is required immediately as a result of an accident or Emergency illness. Emergency Service does not include Dental Service for elective care or care required as a result of circumstances or conditions that could reasonably have been foreseen.

   a. There will be a Group Dentist on call for non-clinic hours to attend to the Participant's Emergency needs within the Service Area.

   b. Participants who receive Emergency Service outside the Service Area, shall be entitled to Benefits for Dental Service not to exceed the lesser of the Charges directly related to Emergency Service or $150.00 per Participant (the maximum allowance). Proof of Emergency Service must be given to the Participant's Group Dentist or CARE-PLUS within thirty (30) days of date of occurrence.

6. DENTAL SERVICES PROVIDED TO THE GROUP. See Addendum B

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
CITY OF DE PERE GROUP NO. PPD281

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D0120	Periodic oral examination – 2 per year	NONE
D0140	Limited oral evaluation – problem focus	NONE
D0145	Oral evaluation for patient <3 years w/counseling w/primary caregiver	NONE
D0150	Comprehensive oral evaluation	NONE
D0210	Intraoral-complete series of radiographic images w/bitewings	NONE
D0220	Intraoral-periapical-first radiographic image	NONE
D0230	Intraoral-periapical-each additional radiographic image	NONE
D0240	Intraoral – occusal radiographic image	NONE
D0270	Bitewing-single radiographic image	NONE
D0272	Bitewing-two radiographic images – 2 per year	NONE
D0274	Bitewing-four radiographic images – 2 per year	NONE
D0277	Vertical bitewings	NONE
D0330	Panoramic radiographic image	NONE
D0460	Pulp vitality tests	NONE
D0470	Diagnostic casts	NONE
PREVENTATIVE		
D1110	Prophylaxis-adult – 2 per year	NONE
D1120	Prophylaxis-child – 2 per year	NONE
D1206	Topical application of fluoride varnish – thru age 15	NONE
D1208	Topical application of fluoride – excluding varnish – thru age 15	NONE
D1310	Nutritional counseling for control of dental disease	NONE
D1330	Oral hygiene instructions	NONE
D1351	Sealant per tooth – thru age 15	NONE
D1353	Sealant repair – per tooth – thru age 15	NONE
D1510	Space maintainer – fixed – unilateral	NONE
D1515	Space maintainer – fixed – bilateral	NONE
D1550	Re-cement/re-bond space maintainer	NONE
RESTORATIVE		
D2140	Amalgam – one surface, primary or permanent	NONE
D2150	Amalgam – two surfaces, primary or permanent	NONE
D2160	Amalgam – three surfaces, primary or permanent	NONE
D2161	Amalgam – four or more surfaces, primary or permanent	NONE
D2330	Resin-based composite – one surface, anterior	NONE
D2331	Resin-based composite – two surfaces, anterior	NONE
D2332	Resin-based composite – three surfaces, anterior	NONE
D2335	Resin-based composite – four or more surfaces, anterior incisal angle	NONE
D2390	Resin-based composite crown, anterior	NONE
D2391	Resin-based composite – one surface, posterior	NONE
D2392	Resin-based composite – two surfaces, posterior	NONE
D2393	Resin-based composite – three surfaces, posterior	NONE
D2394	Resin-based composite – four or more surfaces, posterior	NONE
D2740	Crown – porcelain/ceramic substrate	20%
D2752	Crown – porcelain fused to noble metal	20%

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
CITY OF DE PERE GROUP NO. PPD281

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D2792	Crown – full cast noble metal	20%
D2910	Re-cement or re-bond inlay, onlay, veneer	20%
D2920	Re-cement or re-bond crown	20%
D2921	Reattachment of tooth fragment – incisal edge/cusp	NONE
D2929	Prefabricated porcelain/ceramic crown – primary tooth	20%
D2930	Prefabricated stainless steel crown – primary tooth	20%
D2931	Prefabricated stainless steel crown – permanent tooth	20%
D2932	Prefabricated resin crown	20%
D2933	Prefabricated stainless steel crown w/resin window	20%
D2934	Prefabricated esthetic coasted stainless steel crown – primary tooth	20%
D2940	Protective restoration	NONE
D2950	Core build-up including pins when required	20%
D2951	Pin retention/tooth in addition to restoration	NONE
D2952	Post and core in addition to crown indirectly fabricated	20%
D2954	Prefabricated post and core in addition to crown	20%
D2955	Post removal	NONE
D2960	Labial veneer resin (laminate) chairside	20%
D2980	Crown repair necessitated by restorative material failure	20%
ENDODONTICS		
D3110	Pulp cap – direct excluding final restoration	NONE
D3120	Pulp cap – indirect excluding final restoration	NONE
D3220	Therapeutic pulpotomy excluding final restoration	NONE
D3221	Pulpal debridement, primary and permanent tooth	NONE
D3230	Pulpal therapy, anterior primary tooth	NONE
D3240	Pulpal therapy, posterior primary tooth	NONE
D3310	Endodontic therapy anterior tooth	NONE
D3320	Endodontic therapy bicuspid tooth	NONE
D3330	Endodontic therapy molar tooth	NONE
D3332	Incomplete endodontic therapy procedure	NONE
D3346	Retreatment of previous root canal – anterior	NONE
D3347	Retreatment of previous root canal – bicuspid	NONE
D3348	Retreatment of previous root canal – molar	NONE
D3351	Apexification/recalcification – initial visit. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3352	Apexification/recalcification – interim medication replacement. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3353	Apexification/recalcification – final visit. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3410	Apicoectomy – anterior	NONE
D3421	Apicoectomy – bicuspid (first root)	NONE
D3425	Apicoectomy – molar (first root)	NONE
D3426	Apicoectomy (each additional root)	NONE
D3430	Retrograde filling – per root	NONE
D3450	Root amputation – per root	NONE
D3920	Hemisection not including root canal therapy	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
CITY OF DE PERE GROUP NO. PPD281

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D3950	Canal preparation and fitting of preformed dowel or post	NONE
PERIODONTICS		
D0180	Comprehensive periodontic evaluation	NONE
D4210	Gingivectomy/gingivoplasty/four or more teeth per quadrant	NONE
D4211	Gingivectomy/gingivoplasty/one to three teeth per quadrant	NONE
D4231	Anatomical crown exposure – one to three teeth per quadrant	NONE
D4240	Gingival flap procedure w/root plan/four or more teeth per quadrant	NONE
D4241	Gingival flap procedure w/root plan/one to three teeth per quadrant	NONE
D4249	Clinical crown lengthening – hard tissue	NONE
D4260	Osseous surgery – four or more teeth per quadrant	NONE
D4261	Osseous surgery – one to three teeth per quadrant	NONE
D4263	Bone replacement graft – first site in quadrant	NONE
D4264	Bone replacement graft – each additional site in quadrant	NONE
D4266	Guided tissue regeneration – resorbable barrier, per site	NONE
D4267	Guided tissue regeneration – nonresorbable barrier, per site	NONE
D4270	Pedicle soft tissue graft procedure	NONE
D4273	Subepithelial connective tissue graft procedures, per tooth	NONE
D4274	Distal or proximal wedge procedure	NONE
D4275	Soft tissue allograft	NONE
D4277	Free soft tissue graft procedure first tooth position	NONE
D4278	Free soft tissue graft procedure each additional tooth position	NONE
D4320	Provisional splinting – intracoronal	NONE
D4321	Provisional splinting – extracoronal	NONE
D4341	Scaling and root planing/four or more teeth per quadrant – one per 24 mo.	NONE
D4342	Scaling and root planing/one to three teeth per quadrant – one per 24 mo.	NONE
D4355	Full mouth debridement – one per 18 mo.	NONE
D4381	Localized delivery of chemo agents	NONE
D4910	Periodontal maintenance procedure – one per 12 mo. only	NONE
PROSTHODONTICS, REMOVABLE		
D5110	Complete denture – maxillary	20%
D5120	Complete denture – mandibular	20%
D5130	Immediate denture – maxillary	20%
D5140	Immediate denture – mandibular	20%
D5211	Maxillary partial denture – resin base	20%
D5212	Mandibular partial denture – resin base	20%
D5213	Maxillary partial denture – cast metal frame	20%
D5214	Mandibular partial denture – cast metal frame	20%
D5225	Maxillary partial denture – flexible base	20%
D5226	Mandibular partial denture – flexible base	20%
D5281	Removable unilateral partial denture	20%
D5410	Adjust complete denture – maxillary	20%
D5411	Adjust complete denture – mandibular	20%
D5421	Adjust partial denture – maxillary	20%
D5422	Adjust partial denture – mandibular	20%

ADDENDUM B
PROCEDURE DESCRIPTION
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When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D5510	Repair broken denture	20%
D5520	Replace missing/broken teeth – complete denture each tooth	20%
D5610	Repair resin denture base	20%
D5620	Repair cast framework	20%
D5630	Repair or replace broken clasp	20%
D5640	Replace broken teeth – per tooth	20%
D5650	Add tooth to existing partial denture	20%
D5660	Add clasp to existing partial denture	20%
D5730	Reline complete maxillary denture (chairside)	20%
D5731	Reline complete mandibular denture (chairside)	20%
D5740	Reline maxillary partial denture (chairside)	20%
D5741	Reline mandibular partial denture (chairside)	20%
D5750	Reline complete maxillary denture (lab)	20%
D5751	Reline complete mandibular denture (lab)	20%
D5760	Reline maxillary partial denture (lab)	20%
D5761	Reline mandibular partial denture (lab)	20%
D5850	Tissue conditioning, maxillary	20%
D5851	Tissue conditioning, mandibular	20%
D5899	CU-SEL attachment	20%
D5899	Silicone soft liner	20%
PROSTHODONTICS, FIXED		
D6212	Pontic – cast noble metal	20%
D6242	Pontic – porcelain fused to noble metal	20%
D6245	Pontic – porcelain/ceramic	20%
D6740	Crown – porcelain/ceramic	20%
D6752	Crown – porcelain fused to noble metal	20%
D6792	Crown – full cast noble metal	20%
D6930	Re-cement or re-bond fixed partial denture	20%
D6940	Stress breaker	20%
D6980	Fixed partial denture repair necessitated by material failure	20%
IMPLANTS		
D6010	Surgical placement – endosteal , as indicated in article VII, procedures done in conjunction with fixed complex implant retainer prosthetics are not included	20%
D6040	Surgical placement – eposteal	20%
D6056	Prefabricated abutment	20%
D6057	Custom fabricated abutment	20%
D6058	Abutment supported porcelain/ceramic crown	20%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	20%
D6064	Abutment supported cast metal crown (noble metal)	20%
D6065	Implant supported porcelain/ceramic crown	20%
D6068	Abutment supported retainer for porcelain/ceramic fpd	20%
D6071	Abutment supported retainer for porcelain fused to metal fpd (noble metal)	20%
D6074	Abutment supported retainer for cast metal fpd (noble metal)	20%

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
CITY OF DE PERE GROUP NO. PPD281

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D6075	Implant supported retainer for ceramic fpd	20%
D6080	Implant maintenance procedures	20%
D6092	Re-cement or re-bond implant/abutment supported crown	20%
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	20%
D6100	Implant removal, by report	20%
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	20%
D6111	Implant abutment supported removable denture for edentulous arch-mandibular	20%
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	20%
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	20%
ORAL SURGERY		
D7111	Extraction, coronal remnants – deciduous tooth	NONE
D7140	Extraction, erupted tooth or exposed root	NONE
D7210	Surgical removal of erupted tooth	NONE
D7220	Removal of impacted tooth – soft tissue	NONE
D7230	Removal of impacted tooth – partial bony	NONE
D7240	Removal of impacted tooth – complete bony	NONE
D7241	Removal of impacted tooth – complete bony w/unusual surg. complications	NONE
D7250	Surgical removal of residual tooth roots	NONE
D7260	Oroantral fistula closure	NONE
D7270	Tooth reimplantation and/or stabilization	NONE
D7280	Surgical access of an unerupted tooth	NONE
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	NONE
D7283	Placement of device to facilitate eruption of impacted tooth	NONE
D7285	Incisional biopsy of oral tissue – hard	NONE
D7286	Incisional biopsy of oral tissue – soft	NONE
D7288	Brush biopsy	NONE
D7291	Transeptal fiberotomy	NONE
D7310	Alveoloplasty in conjunction w/extractions – four or more teeth per quad	NONE
D7311	Alveoloplasty in conjunction w/extractions – one to three teeth per quad	NONE
D7320	Alveoloplasty not in conjunction w/extractions – four or more teeth per quad	NONE
D7321	Alveoloplasty not in conjunction w/extractions – one to three teeth per quad	NONE
D7340	Vestibuloplasty-ridge extension	NONE
D7350	Vestibuloplasty-ridge extension complete	NONE
D7471	Removal of lateral (maxilla or mandible) exostosis	NONE
D7472	Removal of torus palatinus	NONE
D7473	Removal of torus mandibularis	NONE
D7485	Surgical reduction of osseous tuberosity	NONE
D7510	Incision and drainage abscess – intraoral soft tissue	NONE
D7910	Suture of recent small wound up to 5 cm	NONE
D7953	Bone replacement graft for ridge preservation – per site	NONE
D7960	Frenulectomy – separate procedure	NONE
D7970	Excision of hyperplastic tissue per arch	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
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When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D7971	Excision of pericoronal gingiva	NONE
D7972	Surgical reduction of fibrous tuberosity	NONE
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment dental pain – minor procedure	NONE
D9210	Local anesthesia not in conjunction with operative or surgical procedures	NONE
D9215	Local anesthesia in conjunction with operative or surgical procedures	NONE
D9219	Eval for deep sedation or general anesthesia (frequency with exams)	NONE
D9220	Deep sedation/general anesthesia – first 30 minutes	NONE
D9221	Deep sedation/general anesthesia – each additional 15 minutes	NONE
D9230	Inhalation of nitrous oxide/analgesia – DDS required	NONE
D9241	Intravenous moderate (conscience) sedation/analgesia – first 30 minutes (when medically necessary)	NONE
D9242	Intravenous moderate (conscience) sedation/analgesia – each additional 15 minutes (when medically necessary)	NONE
D9310	Consultation – per session (frequency with exams)	NONE
D9430	Office visit for observation (during regularly scheduled hours)	NONE
D9630	Other drugs and/or medicaments	NONE
D9910	Application of desensitizing medicaments (dispensed in office)	NONE
D9951	Occlusal adjustment – limited	20%

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDATORY ENDORSEMENT

CITY OF DE PERE
GROUP NO. PPD281

This amendatory endorsement modifies insurance provided to CITY OF DE PERE under your CARE-PLUS DENTAL PLANS, INC., DENTAL CARE GROUP POLICY/CERTIFICATE. This amendatory endorsement is attached to and made part of the Policy/Certificate. Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

The following additional benefits for evidence-based integrated care are added to this policy effective January 1, 2016:

1. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year following periodontal surgery.

2. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for diabetics.

3. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to one time per benefit year during pregnancy.

4. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for patients with any of the following high–risk cardiac conditions.
   - History of infective endocarditis.
   - Certain congenital heart defects (e.g., having one ventricle instead of two).
   - Artificial heart valves.
   - Heart-valve defects caused by acquired conditions like rheumatic heart disease.
   - Hypertrophic cardiomyopathy, which causes abnormal thickening of the heart muscle.
   - Individuals with pulmonary shunts or conduits.
   - Mitral-valve prolapse with regurgitation (blood leakage).
   - Additional heart conditions

5. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for suppressed-immune-system conditions.

6. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for kidney failure or dialysis conditions.

7. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for cancer-related chemotherapy and/or radiation treatments.

Summary Plan Description
Additional Information

Your employer (the "Group") has adopted the CARE-PLUS Dental Plans, Inc. Dental Care Group Policy (the "Plan"). The Plan is an insurance policy CP-401-15 issued by CARE-PLUS Dental Plans, Inc. ("CARE-PLUS").

Detailed and complex legal documents recite the formal text of the Plan. The Certificate of Insurance ("Certificate"), Addendum “A” and “B”, the Procedure Description and this information, comprise the Summary Plan Description (the "SPD") for the Plan. The SPD explains the main provisions of the Plan so that You may understand the Plan's operation and its benefit to You. The SPD cannot change, add to, or subtract from, the formal Plan document. If the SPD and the Plan document are inconsistent, the formal Plan document will control. The Group reserves the right to amend or terminate the Plan at any time and without prior notice. You may inspect a copy of the Plan document at the Group office.

We suggest that You read the SPD carefully. Certain capitalized terms used in the SPD are defined in the Certificate. If You have any questions after reading the SPD, please contact CARE-PLUS at CARE-PLUS Dental Plans, Inc., 3333 N. Mayfair Road, Suite 311, Wauwatosa, WI 53222 or contact the Plan Administrator listed on the Plan Benefit Schedule.

FEDERAL PROVISIONS

1. Qualified Medical Child Support Order. The Plan provides coverage of children pursuant to a qualified medical child support order as defined in the Omnibus Budget Reconciliation Act of 1993. The Plan's procedures for reviewing these orders, are available, without charge, upon written request to the Plan Administrator.

2. Family and Medical Leave Act. All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 ("FMLA"). Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent of such conflict. You should contact Your Group, if You have questions regarding FMLA and the extent to which it applies to You.

3. Uniformed Services Employment and Reemployment Rights Act. If You are returning from military service, You may have rights mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). You should contact Your Group if You have questions regarding USERRA and the extent to which it applies to You.

4. Medicaid. As a group health plan subject to ERISA, the Plan complies with ERISA section 609(b) regarding Medicaid.

5. HIPAA Special Enrollment Rights. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires group health plans to provide special enrollment periods during which previously Eligible Members who declined coverage for themselves and their eligible Dependents may enroll in the Contract without waiting until the next open enrollment period. A special enrollment period occurs under the following circumstances:

1. Loss of Coverage: If You previously declined in writing to enroll Yourself or Your eligible Dependents in the Contract because of other health insurance coverage, You may be able to enroll Yourself and Your Dependents who lose other health insurance coverage. You must request enrollment, in writing, within 30 days after Your and Your eligible Dependents other coverage ends. Your coverage will be effective no later than the first of the month following the date You elect coverage under the Contract.

2. New Dependent: If You acquire a new Dependent through marriage, birth, adoption, or placement for adoption, You may be able to enroll Yourself and Your newly-acquired Dependents in the Contract. You must request enrollment, in writing, within 30 days after the marriage, birth, adoption, or placement for adoption. In the case of birth, adoption or placement for adoption, coverage for the newborn child or the adopted child and You and Your spouse (if not already enrolled) will be effective retroactive to the date of birth, date of adoption or placement for adoption. In the case of marriage, coverage for You and Your new spouse or other eligible Dependents acquired through marriage will be effective no later than the first of the month following the date You elect coverage under the Contract.

You and Your eligible Dependents may have other enrollment rights under the Contract. To the extent any other enrollment rights conflict or overlap with these HIPAA special enrollment rights, You and Your eligible Dependents will be entitled to the most favorable enrollment rights.

6. COBRA. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allows a Participant to continue coverage beyond the date coverage normally ends. An employer may be required to comply with COBRA. The Group must determine whether COBRA applies to it.

You may elect COBRA if you are a Qualified Beneficiary and you lose coverage under this Plan due to a Qualifying Event, subject to the following terms and conditions:

1. Qualified Beneficiaries. You are a Qualified Beneficiary if:

   a. You are a Member or Dependent and were covered by the Contract on the day before the Qualifying Event; or

   b. You are a child born to, or adopted by or placed for adoption with a Member during a COBRA continuation period. You must be eligible for coverage, and the Member must enroll You on a timely basis under the Contract.

2. Qualifying Events. A Qualifying Event is one of the following events that would cause the Qualified Beneficiary to lose coverage within the Maximum Continuation Period:

   a. Termination of the Member's employment (for any reason other than gross misconduct), or reduction in the Member's work hours.

   b. Death of the Member.

   c. Legal separation or divorce from the Member.

   d. Loss of eligibility by a Dependent child due to the termination of Dependent status.

3. Maximum Continuation Period. The Maximum Continuation Period following a Qualifying Event lasts:

   a. Eighteen (18) months from the date of a Qualifying Event stated in 2a above. A Participant may extend this 18-month period as follows:

      (1) Member Entitlement to Medicare. If the Member is entitled to Medicare at the time of an initial Qualifying Event, then the period of continuation for covered Dependents is the later of 36 months from the date of Medicare entitlement, or 18 months from the date of the Qualifying Event.

      (2) Total Disability. The 18 months may be extended up to a total of 29 months from the original Qualifying Event for total disability. A Qualified Beneficiary must be Social Security disabled at the date of the Qualifying Event or become disabled within the first 60 days of continuation coverage.

      (3) Second Qualifying Event. The 18 (or 29) months also may be extended up to a total of 36 months from the original Qualifying Event. An extension is allowed if

during the initial 18 (or 29) months of continuation, one of the Qualifying Events described in 2b through 2d above occurs that would otherwise have caused covered Dependents to lose coverage.

b. Thirty-six (36) months after the date of a Qualifying Event stated in 2b through 2d above.

4. Termination. COBRA continuation coverage will terminate on the earliest of the following dates:

   a. The last day of the period for which the Participant made a timely premium payment.

   b. For a disability extension, the first of the month which is more than 30 days after the Social Security Administration determines that the Qualified Beneficiary is no longer disabled.

   c. The date the Qualified Beneficiary first becomes covered under another group health plan after making a COBRA election. This applies only if the other group plan does not limit the Qualified Beneficiary's coverage under a pre-existing condition limitation.

   d. The date the Qualified Beneficiary first becomes entitled to Medicare, after making a COBRA election.

   e. The Group termination date.

   f. The date the Maximum Continuation Period expires.

5. Group Notification of Qualifying Events. The Group must notify the Group's COBRA administrator of a Member's death, entitlement to Medicare, employment termination or reduction in work hours.

6. Participant Notification of Qualifying Events. The Participant must notify the Group's COBRA administrator in writing of the following events:

   a. Divorce/Legal Separation. Within sixty (60) days of the later of (1) the date of divorce or legal separation from the Member; or (2) the date that the Participant would lose coverage due to this event.

   b. Child Loses Eligibility. Within sixty (60) days of the later of (1) the date that a covered Dependent child loses eligibility (e.g., due to age, loss of student status, marriage, etc.); or (2) the date that the Dependent child would lose coverage due to this event.

   c. Social Security Disability Extension. Within sixty (60) days after the latest of:

(1) The date of the Social Security Administration's disability determination;

(2) The date of the Member's termination of employment or reduction of hours; or

(3) The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the Contract as a result of the Member's termination of employment or reduction of hours.

The Participant also must provide disability notice before the original 18-month continuation period expires.

d. Second Qualifying Event. Within sixty (60) days of the later of: (1) the date of the occurrence of a second Qualifying Event (i.e., divorce, legal separation, Member entitlement to Medicare, or child loss of eligible Dependent status); or (2) the date the Qualified Beneficiary would lose coverage due to the event if the Qualified Beneficiary had still been covered under the Contract.

e. COBRA Notice Procedures. The Participant must provide written notice of the above events. The Participant should provide notice to the Group's COBRA administrator at the following address:

Benefit Advantage
Kathy Nelson
3431 Commodity Lane
Green Bay, WI 54304
920-339-0351 Ext. 152

The notice must contain the following information:

(1) The Plan name;

(2) The Group name;

(3) The Member or former Member's name and address;

(4) The names of all Qualified Beneficiaries who lost coverage due to the event;

(5) The type of event;

(6) The date of the event;

(7) The signature, name and address of the individual sending the notice;

(8) For divorce or legal separation, a copy of the decree of divorce or legal separation; and

(9) For disability extensions, a copy of the Social Security Administration's determination of disability.

Oral notice is unacceptable. Failure to provide proper written notice on a timely basis will result in loss of all rights to continuation of coverage.

7. Notification of Qualifying Events. The Group's COBRA administrator will notify a Participant of the right to elect continuation of coverage after it receives notice of the Qualifying Event. Notice to the Member or the Member's covered spouse is considered notice to all Qualified Beneficiaries residing with the Member or Member's covered spouse.

8. Qualified Beneficiary Notification of Loss of Eligibility for Continuation. A Qualified Beneficiary must notify the Group's COBRA administrator, in writing, within thirty (30) days of either of the following events:

   a. Medicare or Other Group Plan Coverage. A Qualified Beneficiary becomes ineligible for COBRA if he/she becomes entitled to Medicare (Part A or Part B, or both) after making a COBRA election. A Qualified Beneficiary becomes ineligible for COBRA if he/she becomes covered under other group health plan coverage after making a COBRA election. This rule applies only after the Qualified Beneficiary exhausts or satisfies the other plan's preexisting condition exclusions.

   COBRA coverage will terminate as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. Termination may be retroactive. The Qualified Beneficiary must repay the Plan for all benefits paid after the termination date. The Plan requires repayment regardless of whether or when the Qualified Beneficiary provided notice of Medicare entitlement or other plan coverage.

   b. Termination of Social Security Disability. If the Social Security Administration issues a determination that a Qualified Beneficiary is no longer disabled, then continuation coverage terminates. Termination occurs on the first of the month that is more than 30 days after the Social Security Administration determines that he/she is no longer disabled. The Qualified Beneficiary must repay all benefits paid after the termination date. The Plan requires repayment regardless of whether or when he/she provides notice of the Social Security Administration's determination.

   The written notice must include the Plan name, the Group name, the Member or former Member's name, the type of event, the name(s) of any other Qualified Beneficiary affected by the event and the name, address and signature of the Qualified Beneficiary who submits the notice.

9. Election Period. A Participant will be given a period of sixty (60) days to elect COBRA coverage. The Group's COBRA administrator will send the Participant an election form to complete and return. If a Participant initially rejects COBRA, the Participant may

change his/her mind as long as the sixty (60) day election period has not expired. The election period begins on the later of:

a. The date coverage terminates.

b. The date the Group's COBRA administrator notifies the Participant of his/her right to elect continuation coverage.

A terminated Member or the Member's spouse can elect coverage on behalf of all Qualified Beneficiaries in the family. If the terminated Dependent is a minor, his/her parent or guardian may act on his/her behalf. All Qualified Beneficiaries in a family have individual election rights.

10. Special Considerations for COBRA Election. There are special considerations for a COBRA election. A Participant should consider that a failure to elect COBRA will affect future rights under federal law. First, the Participant can lose the right to avoid having preexisting condition exclusions applied to the Participant by other group health plans. A preexisting condition exclusion may apply if the Participant has more than a sixty-three (63) day gap in health coverage. The Participant may not have such a gap if he/she elects COBRA. Second, the Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if the Participant does not get COBRA coverage for the maximum time available. Finally, the Participant should consider that he/she has special enrollment rights under federal law. The Participant has the right to request special enrollment in another group health plan for which the Participant is otherwise eligible (such as a plan sponsored by the Participant's spouse's employer) within thirty (30) days after the Participant's group health coverage under the Plan ends because of a Qualifying Event. The Participant also will have a special enrollment right at the end of COBRA coverage if the Participant gets COBRA coverage for the maximum time available.

11. Premiums and Payments.

a. Amount. The premium charged may not exceed 102% of the effective Group rate. For disability extensions, the premium in the nineteenth (19) through twenty-ninth (29) months may equal 150% of the Group rate. The Participant must make premium payment by check.

b. Initial Payment. If the Participant elects COBRA, he/she does not have to send any payment with the election form. However, the Participant must make his/her initial payment for COBRA coverage not later than forty-five (45) days after the date of the election. (This is the date the election form is postmarked, if mailed. This is the date the election form is received at the address specified for delivery of the election form, if hand-delivered.) If the Participant does not make his/her initial payment for COBRA coverage in full within forty-five (45) days after the date of his/her election, the Participant will lose all COBRA rights under the Plan.

The Participant's initial payment must cover the cost of COBRA coverage from the time his/her coverage under the Plan would have otherwise terminated through the end of the month before the month in which the Participant makes his/her first

monthly payment. The Participant must make sure that the amount of his/her initial payment is correct. The Participant may contact the Group's COBRA administrator to confirm the amount of the initial payment.
The Plan will not process reimbursement claims or pay claims until the Participant elects COBRA and makes his/her first COBRA payment.

c. Monthly Payments. After the Participant makes his/her initial payment for COBRA coverage, the Participant makes subsequent monthly payments. The Group's COBRA administrator will inform the Participant of the monthly amount for each Qualified Beneficiary. Under the Plan, monthly COBRA payments are due on the 1st day of the month for that month's COBRA coverage. The Group's COBRA administrator will not send monthly payment notices. The Participant must pay COBRA premiums on time. If the Participant makes a monthly payment on or before the 1st day of the month, the Participant's COBRA coverage under the Plan will continue for that month without any break.

   Although monthly payments are due on the 1st day of the coverage month to continue COBRA coverage for that month, the Participant will be given a grace period to make payment. The grace period for monthly payments is thirty (30) days from the first day of the month of coverage. The Plan will continue the Participant's COBRA coverage each month as long as the Participant makes payment for that month before the end of the grace period.

   However, if the Participant makes a monthly payment later than the due date, but before the end of the grace period, the Plan will suspend the Participant's COBRA coverage as of the first day of the month. The Plan will retroactively reinstate (going back to the first day of the month) COBRA coverage when the Group's COBRA administrator receives the monthly payment. Any claim the Participant submits for benefits while his/her coverage is suspended may be denied. The Participant may have to resubmit the claim once the Participant's coverage is reinstated.

   If the Participant fails to make a monthly payment before the end of the grace period for that month, he/she will lose all rights to COBRA coverage under the Contract.

d. Where to Make Payments. The Participant's initial payment and all monthly payments for COBRA coverage should be mailed or hand-delivered to the Group's COBRA administrator as follows:

   Benefit Advantage
   PO Box 5545
   De Pere, WI 54115

   If mailed, the Participant's payment is considered to have been made on the date that it is postmarked. If hand-delivered, the Participant's payment is considered to have been made when it is received at the address specified above. The Participant will not be considered to have made any payment by mailing or hand delivering a check if his/her check is returned due to insufficient funds or otherwise.

STATEMENT OF ERISA RIGHTS

Plan Participants are entitled to certain rights and protections pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"). The Group and Plan Administrator intend to comply fully with ERISA. If You have a question about the Plan, how it is run and how it affects You, You should contact the Plan Administrator or CARE-PLUS.

ERISA provides that all Plan Participants shall be entitled to:

1. 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 SPD. 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 Participant with a copy of this summary annual report.

2. Continue Group Dental Plan Coverage

Continue dental care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

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

4. Enforce Your Rights

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

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If You have a claim for Benefits that 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 domestic relations order or 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.

5. Assistance with Your Questions

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

PLAN ADMINISTRATION

The Plan Administrator's responsibilities include (1) maintaining Plan documents at its office, (2) responding to requests for information, (3) providing COBRA notices (if required), and (4) all reporting and disclosure required by the U.S. Department of Labor and the Internal Revenue Service. The Insurer's responsibilities include (1) determining whether an individual is eligible to participate in the Plan, (2) reviewing each claim for Benefits to determine whether a particular service is eligible for coverage under the Plan, and (3) reviewing claim appeals (Grievances). If You have any questions about the Plan, You should contact the Plan Administrator or the Insurer.

Plan Year:

A Plan Year is the 12-month period specified in the Plan Benefit Schedule. All records that relate to the Plan are maintained on a Plan Year basis.

Employer and Plan Numbers:

For reporting Plan information to the U.S. Department of Labor and the Internal Revenue Service, You will need the Employer Identification Number and Plan Number found on the front page of the CERTIFICATE OF INSURANCE.

Plan Sponsor's Name and Address:

City of De Pere
335 S Broadway Street
De Pere, WI 54115

Plan Administrator's Name, Address and Telephone Number:

Benefit Advantage
Kathy Nelson
3431 Commodity Lane
Green Bay, WI 54304
920.339.0351 ext. 152

Insurer's Name, Address and Telephone Number:

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Road, Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
(800) 318-7007

Agent for Service of Legal Process:

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. If the dispute involves a claim of benefits under the Group Contract, additional service of legal process must be made upon the Insurer at the above address or upon the supervisory official of the Department of Insurance in the state in which you reside.

Type of Plan:

The Plan is an employee welfare benefit plan providing dental benefits.

Funding Method:

The Plan is funded by the payment of premium required by the Group Contract. Your contribution (if any) towards the cost of the Plan is at a rate determined and communicated by the Group from time to time.

Plan Amendment and Termination:

While the Plan Sponsor intends to continue this Plan indefinitely, it reserves the right to modify, suspend, or terminate this Plan at any time. The Plan Sponsor does not promise the continuation of benefits nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of Plan Participants following termination are described in this certificate.

The Plan Sponsor adopts all provisions of the Group Contract issued by the Insurer, as amended from time to time, as part of this Plan.