

CITY OF GREEN BAY

DENTAL PLAN 2

EFFECTIVE JANUARY 1, 2008

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PLAN DESCRIPTION INFORMATION

1. Proper Name of Plan: Group Benefit Plan for Employees of the City of Green Bay

Common Name of Plan: City of Green Bay

2. Plan Sponsor and *Employer*: City of Green Bay
100 North Jefferson Street, Room 500
Green Bay, WI 54301
Telephone: (920) 448-3147

Certain classes of *employees* are maintained under a collective bargaining agreement.

3. Plan Administrator and Named Fiduciary:

City of Green Bay
100 North Jefferson Street, Room 500
Green Bay, WI 54301
Telephone: (920) 448-3147

4. *Employer* Identification Number: 39-6005458.

5. The Plan provides dental benefits for participating *employees* and their enrolled *dependents*.

6. Plan benefits described in this booklet are effective January 1, 2008.

7. The *Plan year* and fiscal year are January 1 through December 31 of each year.

8. Service of legal process may be served upon the Plan Administrator as shown above or the following agent for service of legal process:

City Clerk
City of Green Bay
100 North Jefferson Street, Room 106
Green Bay, WI 54301

9. The *Plan Manager* is responsible for performing certain delegated administrative duties, including the processing of claims. The *Plan Manager* is:

HumanaDental Insurance Company
1100 Employers Boulevard
Green Bay, WI 54344
Telephone: (920) 336-1100
Toll Free: 1-800-233-4013

Plan Description Information Continued

10. This is a self-insured dental benefit plan. The cost of the Plan is paid with contributions shared by the *employer* and the *employee*. Benefits under the Plan are provided from the general assets of the *employer* and are used to fund payment of covered claims under the Plan plus administrative expenses. Please see *your employer* for the method of calculating contributions and the funding mechanism used for the accumulation of assets through which benefits are provided under this Plan.
11. Each *employee* of the *employer* who participates in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to *employees* by the *employer*. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.
12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated at any time by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated to participants as required by applicable law.
13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any, will be allocated and disposed of for *expenses incurred* under the Plan.
14. The Plan does not constitute a contract between the *employer* and any *covered person* and will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time. It is provided, however, that the foregoing will not modify the provisions of any collective bargaining agreement which may be made by the *employer* with the bargaining representative of any *employees*.
15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

SCHEDULE OF BENEFITS

NOTE: Italicized terms within the text are defined in the Definitions section of this booklet.

NOTE: IF *YOU* OR ANY OF *YOUR COVERED DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* ARE RESPONSIBLE FOR NOTIFYING *YOUR EMPLOYER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF SUCH NOTICE HAS NOT BEEN GIVEN TO *YOUR EMPLOYER*. FAILURE TO NOTIFY *YOUR EMPLOYER* OF SUCH NOTICE MAY IMPACT ELIGIBILITY UNDER COBRA CONTINUATION.

Agreements have been made with certain *dentists* called in-network *dentists*. All in-network *dentists* have agreed to render *services* at predetermined charges. If *you* receive treatment from an in-network *dentist* *your* benefits will be calculated on these predetermined charges. The Plan Administrator will automatically provide, without charge, information to *you* about how *you* can access a directory of in-network *dentists* appropriate to *your* service area. The in-network *dentist* provider directory will be available in either hard copy as a separate document, or in electronic format. If *you* have questions about whether a particular *dentist* is an in-network *dentist* or need verification about the status of a provider, please contact the *Plan Manager* at 1-800-233-4013, or *your* Plan Administrator. *You* can also visit: www.humanadental.com/dentistfinder.

In-network *dentists* have signed a contract with the *Plan Manager*, agreeing to accept reduced fees for the dental procedures they provide. This reduces *your* out-of-pocket costs. They have also agreed not to charge *you* any amount that exceeds the fees agreed upon, aside from deductibles, coinsurance, and fees for procedures not covered.

If *you* choose to receive *your* dental care from an out-of-network *dentist*, *covered expenses* listed below are payable on a *maximum allowable fee* basis.

You may select any *dentist* to provide *your* dental care.

This schedule provides a brief overview of Plan benefits and is not a complete description. Refer to the text for a detailed description of *your* Plan benefits.

SCHEDULE OF DENTAL BENEFITS		
Individual <i>Maximum Benefit</i>	Preventive, Basic, Major Restorative, Prosthodontic and Orthodontic <i>Services</i>	\$2,500 per <i>calendar year</i>
<i>Calendar Year Deductible</i>	Individual \$50	Family \$150 aggregate
<i>Preventive Services</i>	After deductible, <i>covered expense</i> is payable at 100%.	
<i>Basic Services</i>	After deductible, <i>covered expense</i> is payable at 80%.	
Major Restorative <i>Services</i>	After deductible, <i>covered expense</i> is payable at 80%.	
<i>Prosthodontic Services</i>	After deductible, <i>covered expense</i> is payable at 50%.	
<i>Orthodontic Services</i>	After deductible, <i>covered expense</i> is payable at 50%.	

NOTE: Certain *services* may be covered under *your* medical plan. The medical plan would pay as primary and the dental plan would pay as secondary.

Schedule of Benefits Continued

PREDETERMINATION OF BENEFITS

If *expense incurred* in performing a dental *service* or one series of dental *services* can reasonably be expected to be \$300 or more, the Plan recommends *you* or the provider submit those charges for a *predetermination of benefits*. The *Plan Manager* will advise *you* and the provider what expenses will be covered under the Plan. The *Plan Manager* will take into account alternate procedures, *services*, or courses of treatment based upon professionally endorsed standards of dental care. A *predetermination of benefits* is not a guarantee of benefits. *Services* will be subject to all terms and provisions of the Plan at the time treatment is rendered.

If treatment is to commence more than 180 days after the date treatment is authorized, the Plan will recommend *you* submit another treatment plan.

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

ALTERNATE SERVICES

If two or more *services* are considered to be acceptable to correct the same dental condition, the benefits payable will be based on the *covered expenses* for the least expensive *service* which will produce a professionally satisfactory result.

If *you* or *your dentist* decide on a more costly treatment than the Plan has determined to be satisfactory for treatment of the condition, benefits will be limited to the lesser of the *maximum allowable fee* charge or predetermined charge and are subject to any deductible and coinsurance for the least costly treatment. The excess amount will not be paid by the Plan. The balance of the treatment charge remains the responsibility of the member.

DENTAL BENEFITS

DEDUCTIBLE AND COINSURANCE INFORMATION

This section describes benefits for *covered expenses*. *Covered expense* means *expense incurred* by you for the *services* stated within. The expense must be incurred while you are covered for that benefit under the Plan. *Covered expenses* are payable, after satisfaction of the deductible, if any, on a *maximum allowable fee* basis or predetermined charge at the coinsurance percentages and up to the *maximum benefits* shown on the Schedule of Benefits.

DEDUCTIBLE

The deductible applies to each *covered person* each *calendar year*. Only charges which qualify as a *covered expense* may be used to satisfy the deductible. The amount of the deductible is stated on the Schedule of Benefits.

MAXIMUM FAMILY DEDUCTIBLE

The total deductible applied to all *covered persons* in one family in a *calendar year* is subject to the maximum shown on the Schedule of Benefits.

COINSURANCE

The term coinsurance means the shared financial responsibility for *covered expenses* between the *covered person* and the self-insured plan.

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits after the deductible is satisfied each *calendar year*.

DENTAL COVERED EXPENSES

For all *covered expenses*, study models/diagnostic casts will be considered a combined part of the entire dental *service* rather than a separate *service*.

For all *covered expenses*, temporary dental *services* will be considered an integral part of the entire dental *service*. A separate fee for these *services* is not considered a *covered expense*.

PREVENTIVE SERVICES

Oral examinations. Limited to two examinations per *calendar year*.

Periodontal examinations.

Cleanings (routine prophylaxis). Limited to two per *calendar year*.

Periodontal maintenance.

Bitewing x-rays. Limited to two sets per *calendar year*, but not more than one in any five month period.

Topical fluoride treatment. Limited to two per *calendar year*. A prophylaxis performed in conjunction with a fluoride treatment is considered a separate dental *service*.

Emergency oral examinations and palliative (*emergency*) treatment for relief of dental pain.

Preventive control programs including but not limited to, oral hygiene instruction, plaque control, take home items or dietary planning.

BASIC SERVICES

Amalgam (silver) and composite (tooth colored) fillings. Composite fillings are only covered on the upper or lower anterior and bicuspid teeth. The Plan will allow an alternate benefit of the cost of an amalgam filling for any composite filling applied on molar teeth. The difference between the cost of the amalgam and composite filling will be the responsibility of the plan member.

Local anesthetics and analgesia.

General anesthesia.

Routine extractions, other than orthodontic extractions. Extraction and initial replacement of natural teeth are covered under the medical plan as primary.

Surgical extractions of erupted teeth. Extraction and initial replacement of natural teeth are covered under the medical plan as primary.

Oral surgery, including surgical extractions of impacted teeth. Oral surgery including pre- and post-operative care. Extraction and initial replacement of natural teeth are covered under the medical plan as primary.

Basic Services Continued

Osteotomies.

Services for the diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including but not limited to charges for: TMJ exams, x-rays and consultations; TMJ surgery, kinesiographic analysis and muscle testing; TMJ splints and appliances; splint equilibration and adjustments or physical therapy for symptoms including but not limited to, headaches.

Prescription drugs or premedications administered by a *dentist* in the office and billed with a valid CDT code. This does not include coverage for written prescriptions.

Drug injections, when done in conjunction with oral surgery.

Periodontics including procedures necessary for the treatment of disease of the gums and bone supporting the teeth. Periodontal root planing and scaling is payable with no frequency limitations. The benefits for periodontal surgery include three months post surgical care. Periodontal surgery is covered under the medical plan as primary.

Full mouth debridement. Limited to once per lifetime.

Site therapy. When the *covered person* has had prior periodontal therapy performed and pocket depths are 5mm or greater.

Splinting procedures.

Pulp caps/bases.

Endodontics. Vital pulpotomies on primary and permanent teeth, root canal treatments and pulp vitality tests. Final restorations are considered a separate *service*.

Recementation of inlays/onlays, crowns, bridges and veneers.

Occlusal guards, when done in conjunction with periodontal surgery or for bruxism, including their reline/repair.

Stainless steel crowns.

Occlusal adjustments, when done in conjunction with periodontal surgery.

Full mouth x-rays.

Panorex x-rays.

Miscellaneous x-rays including but not limited to periapical x-rays.

Sealants.

Basic Services Continued

Space maintainers. For fixed or removable appliances to maintain a space created by the premature loss of a primary tooth or teeth.

Lab tests.

LIMITATIONS FOR BASIC SERVICES

If *you* are a *late applicant* as defined in this Plan, *Basic Services* are not a *covered expense* until *you* have been covered under the Plan for 12 consecutive months. The *late applicant* provision will be waived if *services* are due to an *accidental injury*.

MAJOR RESTORATIVE SERVICES*

**Services* are only available when performed on permanent teeth.

Gold foil fillings and their maintenance/repairs.

Inlays or onlays and their maintenance/repairs.

Crowns and their maintenance/repairs.

Post/core build-ups for crowns.

Porcelain. Limited to the upper or lower anterior and bicuspid teeth.

Veneers and their maintenance/repairs. Limited to the upper or lower anterior and bicuspid teeth.

Installation and maintenance/repairs of removable or fixed bridgework. Initial replacement of natural teeth is covered under the medical plan as primary.

Post/core build-ups for bridgework.

Installation and maintenance/repairs of partial dentures, including six months post-installation care. Initial replacement of natural teeth is covered under the medical plan as primary.

Installation and maintenance/repairs of overdentures, including six months post-installation care. Initial replacement of natural teeth is covered under the medical plan as primary.

Maintenance/repairs of complete dentures.

Procedures to reline and rebase.

Tissue conditioning.

Precision or semi-precision attachments.

Stressbreakers.

Major Restorative Services Continued

Implants, including the post, abutment, prosthesis placed over the implant post, adjustments, maintenance, and repairs, including six months post-installation care. The Alternate Benefit provision will not apply. Implants are not covered under the medical plan sponsored by the City of Green Bay. If the *covered person* is covered by another medical plan, not sponsored by the City of Green Bay, any coverage under the other medical plan will pay as primary and this Plan will pay as secondary.

Services to replace congenitally missing teeth.

LIMITATIONS FOR MAJOR RESTORATIVE SERVICES

Replacement of a partial denture, overdenture, or implant will be a *covered expense* only if the existing partial denture, overdenture, or implant was installed at least five years prior to its replacement and cannot be made serviceable; unless:

1. Replacement is *dentally necessary* due to the placement of an initial opposing full denture or the extraction of natural teeth rendering the partial denture, overdenture, or implant unserviceable; or
2. The partial denture, overdenture, or implant, while in the oral cavity, is damaged beyond repair as a result of an *accidental injury* received while *you* are covered under the Plan.

Expense incurred for Major Restorative *Services* to replace at any time a partial denture or overdenture which meets or can be made to meet commonly held dental standards of functional acceptability is not a *covered expense*.

If *you* are a *late applicant* as defined in this Plan, Major Restorative *Services* are not a *covered expense* until *you* have been covered under the Plan for 12 consecutive months. The *late applicant* provision will be waived if *services* are due to an *accidental injury*.

PROSTHODONTIC SERVICES*

**Services* are only available when performed on permanent teeth.

Installation of complete dentures, including six months post-installation care. Initial replacement of natural teeth is covered under the medical plan as primary.

LIMITATIONS FOR PROSTHODONTIC SERVICES

Replacement of a complete denture will be a *covered expense* only if the existing complete denture was installed at least five years prior to its replacement and cannot be made serviceable; unless:

1. Replacement is *dentally necessary* due to the placement of an initial opposing full denture or the extraction of natural teeth rendering the denture unserviceable; or
2. The complete denture, while in the oral cavity, is damaged beyond repair as a result of an *accidental injury* received while *you* are covered under the Plan.

Expense incurred for Prosthodontic *Services* to replace at any time a complete denture which meets or can be made to meet commonly held dental standards of functional acceptability is not a *covered expense*.

Prosthodontic Services Continued

If you are a *late applicant* as defined in this Plan, Prosthodontic *Services* are not a *covered expense* until you have been covered under the Plan for 12 consecutive months. The *late applicant* provision will be waived if services are due to an *accidental injury*.

ORTHODONTIC SERVICES

Benefits for Orthodontic *Services* are payable as shown on the Schedule of Benefits.

Orthodontic treatment means braces and necessary adjustments and *expense incurred* for:

1. Treatment and appliances for tooth guidance, interception and correction; including harmful habit appliances.
2. *Services* related to covered orthodontic treatment; including records and extractions.

Benefit payments for orthodontic treatment are prorated by the *Plan Manager* over the treatment period. The lesser of twenty-five percent (25%) of the total case fee or the *dentist's* fee will be allowed for the down payment. The balance is pro-rated monthly over the treatment period. If for any reason the treatment plan is terminated before completion of the treatment, no further benefits are payable. If such *services* are resumed, benefits for the *services*, to the extent remaining, shall be resumed.

LIMITATIONS FOR ORTHODONTIC SERVICES

If you are a *late applicant* as defined in this Plan, Orthodontic *Services* are not a *covered expense* until you have been covered under the Plan for 12 consecutive months. The *late applicant* provision will be waived if *services* are due to an *accidental injury*.

LIMITATIONS AND EXCLUSIONS

The Plan does not provide benefits for:

1. Any *accidental injury* 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 or Occupational Disease Act or Law; or
 - b. Coverage was available under any Workers' Compensation or Occupational Disease Act or Law regardless of whether such coverage was actually purchased;
2. *Services* and supplies:
 - a. For which no charge is made, or for which *you* would not be required to pay if *you* did not have coverage unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
 - b. Furnished by or payable under any plan or law through any government or any political subdivision, this does not include *Medicare* or Medicaid; or
 - c. Furnished for a military service connected *accidental injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veterans Affairs;
3. Any loss caused by or contributed to:
 - a. War or any act of war, whether declared or not; or
 - b. Any act of international armed conflict, or any conflict involving armed forces of any international authority;
4. Completion of forms or failure to keep an appointment with the *dentist*;
5. Replacement of lost or stolen dentures or other prosthetic devices;
6. Any *service* which is considered *cosmetic dentistry*, unless such *service* is necessary as a result of an *accidental injury* sustained while covered under this Plan. The following are considered *cosmetic dentistry*:
 - a. Porcelain on crowns, abutments or pontics on molar teeth. Alternate *services* will be applied allowing benefits for a full cast restoration; or
 - b. Personalization or characterization of prosthetic devices;
7. Sterilization/infection control fees;

Limitations and Exclusions Continued

8. Fees for treatment by other than a *dentist*, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;
9. Any hospital charges or for *services* of any anesthesiologist;
10. General anesthesia unless administered by a *dentist*;
11. Major Restorative and Prosthodontic *Services* on other than permanent teeth;
12. *Services* not *dentally necessary* or *services* which do not have uniform professional endorsement;
13. Orthodontic *Services* unless specified in the Schedule of Benefits;
14. The extent the expense exceeds the *maximum allowable fee* or predetermined charge for the *service*, treatment or supply in the locality where furnished;
15. Expenses incurred by a *late applicant* as defined in this booklet;
16. Any *expense incurred* prior to *your* effective date under the Plan or after the date *your* coverage under this Plan terminates;
17. Veneers and their maintenance/repairs on molar teeth;
18. Athletic mouth guards;
19. Any *service* not specifically listed as a *covered expense*;
20. Any *covered expenses* to the extent of any amount received from others for the *accidental injuries* or losses which necessitate such benefits. "Amounts received from others" specifically includes, without limitation, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

NOTE: IF *YOU* OR ANY OF *YOUR* COVERED *DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* ARE RESPONSIBLE FOR NOTIFYING *YOUR EMPLOYER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF SUCH NOTICE HAS NOT BEEN GIVEN TO *YOUR EMPLOYER*. FAILURE TO NOTIFY *YOUR EMPLOYER* OF SUCH NOTICE MAY IMPACT ELIGIBILITY UNDER COBRA CONTINUATION.

EMPLOYEE ELIGIBILITY

You are eligible for coverage if the following conditions are met:

1. *You* are an *employee* who meets the eligibility requirements of the *employer*; and
2. *You* are in *active status*.

If *you* are employed on the first through the fifth day of the month, *you* are eligible for coverage on *your* employment date. If *you* are employed on the sixth through the thirty-first day of the month, *you* are eligible for coverage on the first of the month following *your* employment date.

EMPLOYEE EFFECTIVE DATE OF COVERAGE

You must enroll in a manner acceptable to the *Plan Manager*.

1. If *your* completed enrollment is received by the *Plan Manager* before *your* eligibility date or within 30 days after *your* eligibility date, *you* are a *timely applicant* and *your* coverage is effective on *your* eligibility date.
2. If *your* completed enrollment is received by the *Plan Manager* more than 30 days after *your* eligibility date, *you* are a *late applicant*. *Your* coverage will be effective the first of the month following receipt of completed enrollment.

EMPLOYEE DELAYED EFFECTIVE DATE

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*. The *employer* must notify the *Plan Manager* in writing of the *employee's* return to *active status*.

DEPENDENT ELIGIBILITY

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or
2. The date of the *employee's* marriage for any *dependent* acquired on that date; or
3. The date of birth of the *employee's* natural-born child; or

Eligibility and Effective Date of Coverage Continued

4. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or
5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a qualified medical child support order.

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage.

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE EMPLOYEE’S LEVEL OF COVERAGE IS NOT REQUIRED

If the *employee* wishes to add a newborn *dependent* or a *dependent* acquired through marriage, adoption, placement for adoption or appointment of legal guardianship as ordered by a court to the Plan and a change in the *employee's* level of coverage is not required, enrollment must be completed and submitted to *your employer*.

The newborn *dependent* will be covered on the date he or she is eligible.

If the *employee* wishes to add a *dependent* (other than a newborn or a *dependent* acquired through marriage, adoption, placement for adoption or appointment of legal guardianship as ordered by a court) to the Plan and a change in the *employee's* level of coverage is not required, the *dependent's* effective date of coverage is determined as follows:

1. If completed enrollment is received by *your employer* before the *dependent's* eligibility date or within 30 days (31 days after date of marriage) after the *dependent's* eligibility date, that *dependent* is a *timely applicant* and covered on the date he or she is eligible.
2. If completed enrollment is received by *your employer* more than 30 days (31 days after date of marriage) after the *dependent's* eligibility date, the *dependent* is a *late applicant*. The *dependent's* coverage will be effective the first of the month following receipt of completed enrollment, subject to *late applicant* provisions.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *employee*.

Eligibility and Effective Date of Coverage Continued

DEPENDENT EFFECTIVE DATE OF COVERAGE – WHEN A CHANGE IN THE EMPLOYEE’S LEVEL OF COVERAGE IS REQUIRED

If the *employee* wishes to add a *dependent* to the Plan and a change in the *employee’s* level of coverage is required, enrollment must be completed and submitted to *your employer*.

The *dependent’s* effective date of coverage is determined as follows:

1. If completed enrollment is received by *your employer* before the *dependent’s* eligibility date or within 30 days (31 days after date of marriage) after the *dependent’s* eligibility date, that *dependent* is a *timely applicant* and covered on the date he or she is eligible.
2. If completed enrollment is received by *your employer* more than 30 days (31 days after date of marriage) after the *dependent’s* eligibility date, the *dependent* is a *late applicant*. The *dependent’s* coverage will be effective the first of the month following receipt of completed enrollment, subject to *late applicant* provisions.

No *dependent’s* effective date will be prior to the covered *employee’s* effective date of coverage. If *your dependent* child becomes an eligible *employee* of the *employer*, he or she is no longer eligible as *your dependent* and must make application as an eligible *employee*.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

An individual who is a child of a covered *employee* shall be enrolled for coverage under the Plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO).

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered *employee’s* child; (b) provides for dental care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is “qualified” in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

Procedures for determining the qualified status of qualified medical child support orders are available at no cost upon request from the Plan Administrator.

REINSTATEMENT OF COVERAGE FOLLOWING INACTIVE STATUS

If *your* coverage under the Plan was terminated after a period of layoff, total disability, approved medical leave of absence or approved non-medical leave of absence, *you* are considered a new hire. If *you* are employed on the first through the fifth day of the month, *you* are eligible for coverage on *your* employment date. If *you* are employed on the sixth through the thirty-first day of the month, *you* are eligible for coverage on the first of the month following *your* employment date.

If *your* coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work.

Eligibility and Effective Date of Coverage Continued

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If *you* are granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, *you* may continue to be covered under the Plan for the duration of the Leave as required by that law. See *your employer* for further information.

RETIREE COVERAGE

If *you* are an *employee* and retire from active employment with the *employer*, *you* may be able to continue coverage under the Plan. Please see *your employer* for further information.

SURVIVORSHIP CONTINUATION

If the *employee* dies while *dependent* coverage is in force, the surviving *dependent* spouse and *dependent* children may continue as long as premium is paid, until the earliest of the following:

1. For the surviving *dependent* spouse, attaining age 65;
2. For a *dependent* child, until no longer eligible as a *dependent* as defined under this Plan. See *Dependent* definition on pages 34-35;
3. The date the surviving dependent spouse remarries;
4. The date this policy terminates or the date the *employer* terminates participation under this Plan.

Any *dependents* acquired through the remarriage of the *employee's* surviving spouse will not be eligible for coverage under the Plan.

TERMINATION OF COVERAGE

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The end of the calendar month *you* enter full-time military, naval or air service;
4. The end of the calendar month *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer*;
5. For all *employees*, the end of the calendar month in which *you* terminate employment with *your employer*;
6. For all *employees*, the end of the calendar month *you* retire, except coverage may continue under the Retiree Coverage section of this Plan. See page 16;
7. For any benefit, the date the benefit is removed from the Plan;
8. For *your dependents*, the date *your* coverage terminates;
9. For a *dependent*, the end of the calendar month the *dependent* enters full-time military, naval or air service;
10. For a *dependent* age 19, the end of the *calendar year*;
11. For a *dependent* age 20, age 21, age 22 or age 23, the end of the calendar month such *covered person* no longer is a full-time student under the *dependent* definition. If such *dependent* is a full-time student, coverage will continue until the end of the *calendar year you* turn age 23, unless *you* meet #12 & #13 below. See the definition of Dependent on pages 34-35;
12. For a *dependent* full-time student who graduates during the Spring or Summer semester, coverage will terminate at the end of the day on August 31;
13. For a *dependent* full-time student who graduates during the Fall semester, coverage will terminate at the end of the day on December 31;
14. For a *dependent*, the date the *dependent* ceases to qualify under the definition of *dependent*; or
15. The end of the calendar month *you* request termination of coverage to be effective for yourself and/or *your dependents*.

IF *YOU* OR ANY OF *YOUR COVERED DEPENDENTS* NO LONGER MEET THE ELIGIBILITY REQUIREMENTS, *YOU* ARE RESPONSIBLE FOR NOTIFYING *YOUR EMPLOYER* OF THE CHANGE IN STATUS. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY EVEN IF SUCH NOTICE HAS NOT BEEN GIVEN TO *YOUR EMPLOYER*. FAILURE TO NOTIFY *YOUR EMPLOYER* OF SUCH NOTICE MAY IMPACT ELIGIBILITY UNDER COBRA CONTINUATION.

CONTINUATION OF DENTAL BENEFITS

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

CONTINUATION OF BENEFITS

On April 7, 1986, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was signed into law. This federal law applies to employers with 20 or more employees. The law requires that employers offer employees and/or their dependents continuation of dental coverage at group rates in certain instances where there is a loss of group insurance coverage.

ELIGIBILITY

A qualified beneficiary under COBRA law means an *employee*, *employee's* spouse or *dependent* child covered by the Plan on the day before a qualifying event. A qualified beneficiary under COBRA law also includes a child born to the *employee* during the coverage period or a child placed for adoption with the *employee* during the coverage period.

EMPLOYEE: An *employee* covered by the *employer's* Plan has the right to elect continuation coverage if coverage is lost due to one of the following qualifying events:

- Termination (for reasons other than gross misconduct, as defined by *your employer*) of the *employee's* employment or reduction in the hours of *employee's* employment; or
- Termination of retiree coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

SPOUSE: A spouse covered by the *employer's* Plan has the right to elect continuation coverage if the group coverage is lost due to one of the following qualifying events:

- The death of the *employee*;
- Termination of the *employee's* employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction of the *employee's* hours of employment with the *employer*;
- Divorce or legal separation from the *employee*;
- The *employee* becomes entitled to *Medicare* benefits; or
- Termination of a retiree spouse's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

DEPENDENT CHILD: A *dependent* child covered by the *employer's* Plan has the right to continuation coverage if group coverage is lost due to one of the following qualifying events:

- The death of the *employee* parent;
- The termination of the *employee* parent's employment (for reasons other than gross misconduct, as defined by *your employer*) or reduction in the *employee* parent's hours of employment with the *employer*;
- The *employee* parent's divorce or legal separation;
- Ceasing to be a "*dependent* child" under the Plan;
- The *employee* parent becomes entitled to *Medicare* benefits; or
- Termination of the retiree parent's coverage when the former *employer* discontinues retiree coverage within one year before or one year after filing for Chapter 11 bankruptcy.

COBRA Continued

LOSS OF COVERAGE

Coverage is lost in connection with the foregoing qualified events, when a covered *employee*, spouse or *dependent* child ceases to be covered under the same Plan terms and conditions as in effect immediately before the qualifying event (such as an increase in the premium or contribution that must be paid for *employee*, spouse or *dependent* child coverage).

If coverage is reduced or eliminated in anticipation of an event (for example, an *employer* eliminating an *employee's* coverage in anticipation of the termination of the *employee's* employment, or an *employee* eliminating the coverage of the *employee's* spouse in anticipation of a divorce or legal separation), the reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

A loss of coverage need not occur immediately after the event, so long as it occurs before the end of the Maximum Coverage Period.

NOTICES AND ELECTION

The Plan provides that coverage terminates, for a spouse due to legal separation or divorce or for a child when that child loses *dependent* status. Under the law, the *employee* or qualified beneficiary has the responsibility to inform the Plan Administrator (see Plan Description Information) if one of the above events has occurred. The qualified beneficiary must give this notice within 60 days after the event occurs. (For example, an ex-spouse should make sure that the Plan Administrator is notified of his or her divorce, whether or not his or her coverage was reduced or eliminated in anticipation of the event). When the Plan Administrator is notified that one of these events has happened, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

For a qualified beneficiary who is determined under the Social Security Act to be disabled at any time during the first 60 days of COBRA coverage, the continuation coverage period may be extended 11 additional months. The disability that extends the 18-month coverage period must be determined under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act. To be entitled to the extended coverage period, the disabled qualified beneficiary must provide notice to the Plan Administrator within the initial 18 month coverage period and within 60 days after the date of the determination of disability under the Social Security Act. Failure to provide this notice will result in the loss of the right to extend the COBRA continuation period.

For termination of employment, reduction in work hours, the death of the *employee*, the *employee* becoming covered by *Medicare* or loss of retiree benefits due to bankruptcy, it is the Plan Administrator's responsibility to notify the qualified beneficiary of the right to elect continuation coverage.

Under the law, continuation coverage must be elected within 60 days after Plan coverage ends, or if later, 60 days after the date of the notice of the right to elect continuation coverage. If continuation coverage is not elected within the 60 day period, the right to elect coverage under the Plan will end.

A covered *employee* or the spouse of the covered *employee* may elect continuation coverage for all covered *dependents*, even if the covered *employee* or spouse of the covered *employee* or all covered *dependents* are covered under another group dental plan (as an *employee* or otherwise) prior to the election. The covered *employee*, his or her spouse and *dependent* child, however, each have an independent right to elect continuation coverage. Thus a spouse or *dependent* child may elect continuation coverage even if the covered *employee* does not elect it.

COBRA Continued

Coverage will not be provided during the election period. However, if the individual makes a timely election, coverage will be provided from the date that coverage would otherwise have been lost. If coverage is waived before the end of the 60 day election period and the waiver revoked before the end of the 60 day election period, coverage will be effective on the date the election of coverage is sent to the Plan Administrator.

MAXIMUM COVERAGE PERIOD

Coverage may continue up to:

- 18 months for an *employee* and/or *dependent* whose group coverage ended due to termination of the *employee's* employment or reduction in hours of employment;
- 36 months for a spouse whose coverage ended due to the death of the *employee* or retiree, divorce, or the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event;
- 36 months for a *dependent* child whose coverage ended due to the divorce of the *employee* parent, the *employee* becoming entitled to *Medicare* at the time of the initial qualifying event, the death of the *employee*, or the child ceasing to be a *dependent* under the Plan;
- For the retiree, until the date of death of the retiree who is on continuation due to loss of coverage within one year before or one year after the *employer* filed Chapter 11 bankruptcy.

DISABILITY

An 11-month extension of coverage may be available if any of the qualified beneficiaries are determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide notice of such determination prior to the end of the initial 18-month continuation period to be entitled to the additional 11 months of coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If a qualified beneficiary is determined by SSA to no longer be disabled, *you* must notify the Plan of that fact within 30 days after SSA's determination.

SECOND QUALIFYING EVENT

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

COBRA Continued

TERMINATION BEFORE THE END OF MAXIMUM COVERAGE PERIOD

Continuation coverage will terminate before the end of the maximum coverage period for any of the following reasons:

- The *employer* no longer provides group dental coverage to any of its *employees*;
- The premium for continuation is not paid timely;
- The individual on continuation becomes covered under another group dental plan (as an *employee* or otherwise);
- The individual on continuation becomes entitled to *Medicare* benefits;
- If there is a final determination under Title II or XVI of the Social Security Act that an individual is no longer disabled; however, continuation coverage will not end until the month that begins more than 30 days after the determination;
- The occurrence of any event (e.g. submission of a fraudulent claim) permitting termination of coverage for cause under the Plan.

TYPE OF COVERAGE; PREMIUM PAYMENT

If continuation coverage is elected, the coverage must be identical to the coverage provided under the *employer's* Plan to similarly situated non-COBRA beneficiaries. This means that if the coverage for similarly situated non-COBRA beneficiaries is modified, coverage for the individual on continuation will be modified.

The initial premium payment for continuation coverage is due by the 45th day after coverage is elected. The initial premium includes charges back to the date the continuation coverage began. All other premiums are due on the first of the month for which the premium is paid, subject to a 30 day grace period. The *employer* must provide the individual with a quote of the total monthly premium.

Premium for continuation coverage may be increased, however, the premium may not be increased more than once in any determination period. The determination period is a 12 month period which is established by the Plan.

The monthly premium payment to the Plan for continuing coverage must be submitted directly to the *employer*. This monthly premium may include the *employee's* share and any portion previously paid by the *employer*. The monthly premium must be a reasonable estimate of the cost of providing coverage under the Plan for similarly situated non-COBRA beneficiaries. The premium for COBRA continuation coverage may include a 2% administration charge. However, for qualified beneficiaries who are receiving up to 11 months additional coverage (beyond the first 18 months) due to disability extension (and not a second qualifying event), the premium for COBRA continuation coverage may be up to 150% of the applicable premium for the additional months. Qualified beneficiaries who do not take the additional 11 months of special coverage will pay up to 102% of the premium cost.

NOTE: PAYMENT WILL NOT BE CONSIDERED MADE IF A CHECK IS RETURNED FOR NON-SUFFICIENT FUNDS.

COBRA Continued

OBLIGATIONS WHILE ON COBRA CONTINUATION

You or a *family member* must notify the Plan within 30 calendar days when any of the following events occur:

- A. Any qualified beneficiary becomes entitled to *Medicare*;
- B. Any qualified beneficiary becomes covered by another employer-sponsored group dental plan;
- C. If a disabled *employee* or *family member* is determined by the Social Security Administration to be no longer disabled;
- D. Any qualified beneficiary's marital status changes;
- E. Any *dependent* child ceases to meet the eligibility requirements for plan coverage;
- F. When a child is born to or adopted by any qualified beneficiary;
- G. If the mailing address changes for *you* or *your* spouse.

Events A, B and C above may result in the termination of COBRA continuation coverage. If events D, E or F occur, additional COBRA rights may apply.

OTHER INFORMATION

Additional information regarding rights and obligations under the Plan and under federal law may be obtained by contacting the Plan Administrator or the *Plan Manager*.

It is important for the *covered person* or qualified beneficiary to keep the Plan Administrator and *Plan Manager* informed of any changes in marital status, or a change of address.

PLAN CONTACT INFORMATION

City of Green Bay
100 North Jefferson Street, Room 500
Green Bay, WI 54301
1-920-448-3147

HumanaDental Insurance Company
P.O. Box 14209
Lexington, KY 40512-4209
1-800-232-2006

THE UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that dental plans must offer to continue coverage for *employees* who are absent due to service in the uniformed services and/or their *dependents*. Coverage may continue for up to 18 or 24 months after the date the *employee* is first absent due to uniformed service.

ELIGIBILITY

An *employee* is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, the commissioned corps of the Public Health Service or any other category of person designated by the President of the United States of America in a time of war or emergency. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An *employee's dependent* who has coverage under the Plan immediately prior to the date of the *employee's* covered absence is eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the *employee* or *dependent* is responsible for payment of the applicable cost of coverage. If the *employee* is absent for 30 days or less, the cost will be the amount the *employee* would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the Plan. This includes the *employees* share and any portion previously paid by the *employer*.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue until the earlier of:

- 18 months beginning the first day of absence from employment due to service in the uniformed services for elections made prior to 12/10/04; or
- 24 months beginning the first day of absence from employment due to service in the uniformed services for elections beginning on or after 12/10/04; or
- The day after the *employee* fails to apply for or return to employment as required by USERRA, after completion of a period of service.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an *employee* and/or eligible *dependents*.

OTHER INFORMATION

Employees should contact their *employer* with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the *employer* of any changes in marital status, or a change of address.

CLAIM INFORMATION

NOTICE OF CLAIM

Written notice of claim must be given to the *Plan Manager* without delay, but no later than required by the Proof of Loss provision. Notice may be given to the *Plan Manager* as described in the How to File a Dental Claim section.

PROOF OF LOSS

Claims must be submitted within 15 months from the date of loss, except if *you* were legally incapacitated.

HOW TO FILE A DENTAL CLAIM

You will receive an identification (ID) card which will contain information regarding *your* coverage. Present *your* ID card to the *dentist's* office for dental *services*. The bills can be submitted on the provider's own claim forms and sent directly to the *Plan Manager*. No special claim forms are required. *You* can mail the bills to the *Plan Manager* if the facility or *dentist* providing *services* does not forward them.

Dental claims and correspondence should be mailed to:

HumanaDental Claims Office
P.O. Box 14611
Lexington, KY 40512-4611

Be sure each bill shows the group number and plan member number (the *employee's* unique member identification number) found on *your* ID card. The *employee's* name and the name of the person who received dental *services* or treatment also should be included.

Claim Information Continued

PAYMENT OF CLAIMS

The *Plan Manager* will make direct payment to the *dentist's* office, unless the *Plan Manager* is advised in writing that *you* have already paid the bill. If *you* have paid the bill please indicate on the original statement "paid by *employee*" and send it directly to the *Plan Manager*. *You* will receive a written explanation of the benefit determination. The *Plan Manager* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

When an *employee's* child is subject to a qualified medical child support order, the *Plan Manager* will make reimbursement of eligible expenses paid by *you*, the child, the child's non-employee custodial parent, or legal guardian, to that child or the child's custodial parent, or legal guardian, or as provided in the qualified medical child support order.

Benefits payable on behalf of *you* or *your* covered *dependent* after death will be paid, at the Plan's option, to *your* estate.

The *Plan Manager* will rely upon an affidavit to determine benefit payment, unless it receives written notice of valid claim before payment is made. The affidavit will release the Plan from further liability.

Any payment made by the *Plan Manager* in good faith will fully discharge it to the extent of such payment.

Payments due under the Plan will be paid upon receipt of written proof of loss.

COORDINATION OF BENEFITS

BENEFITS SUBJECT TO THIS PROVISION

Benefits described in this Plan are coordinated with benefits provided by other plans under which *you* are also covered. This is to prevent duplication of coverage and a resulting increase in the cost of dental coverage.

For this purpose, a plan is one which covers medical or dental expenses and provides benefits or *services* by group, franchise or blanket insurance coverage. This includes group-type contracts not available to the general public, obtained and maintained only because of the *covered person's* membership in or connection with a particular organization or group, whether or not designated as franchise, blanket, or in some other fashion. Plan also includes any coverage provided through the following:

1. Employer, trustee, union, employee benefit, or other association; or
2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid.

EFFECT ON BENEFITS

One of the plans involved will pay benefits first. This is called the primary plan. All other plans are called secondary plans.

When this Plan is the secondary plan, the sum of the benefit payable will not exceed 100% of the total allowable expenses incurred under the Plan and any other plans included under this provision.

ORDER OF BENEFIT DETERMINATION

In order to pay claims, it must be determined which plan is primary and which plan(s) are secondary. A plan will pay benefits first if it meets one of the following conditions:

1. The plan has no coordination of benefits provision;
2. The plan covers the person as an *employee*;
3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the *calendar year* pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

Coordination of Benefits Continued

4. In the case of *dependent* children covered under the plans of divorced or separated parents, the following rules apply:
 - a. The plan of a parent who has custody will pay the benefits first;
 - b. The plan of a step-parent who has custody will pay benefits next;
 - c. The plan of a parent who does not have custody will pay benefits next;
 - d. The plan of a step-parent who does not have custody will pay benefits next.

There may be a court decree which gives one parent financial responsibility for the dental expenses of the *dependent* children. If there is a court decree, the rules stated above will not apply if they conflict with the court decree. Instead, the plan of the parent with financial responsibility will pay benefits first.

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. 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 will be ignored.

If the above rules do not apply or cannot be determined, then the plan that covered the person for the longest period of time will pay first.

RIGHT OF RECOVERY

The Plan reserves the right to recover benefit payments made for an allowable expense under the Plan in the amount which exceeds the maximum amount the Plan is required to pay under these provisions. This right of recovery applies to the Plan against:

1. Any person(s) to, for or with respect to whom, such payments were made; or
2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

The Plan alone will determine against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

The *beneficiary* agrees that by accepting and in return for the payment of *covered expenses* by the Plan in accordance with the terms of this Plan:

1. The Plan shall be repaid the full amount of the *covered expenses* it pays from any amount received from others for the *accidental injuries* or losses which necessitated such *covered expenses*. "Amounts received from others" specifically includes, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments.
2. The Plan's right to repayment is, and shall be, prior and superior to the right of any other person or entity, including the *beneficiary*.
3. The right to recover amounts from others for the *accidental injuries* or losses which necessitate *covered expenses* is jointly owned by the Plan and the *beneficiary*. The Plan is subrogated to the *beneficiary's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the Plan as prescribed above; the Plan has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the Plan is subrogated are, and shall be, prior and superior to the rights of any other person or entity, including the *beneficiary*.
4. The *beneficiary* will cooperate with the Plan in any effort to recover from others for the *accidental injuries* or losses which necessitate *covered expense* payments by the Plan. The *beneficiary* will notify the Plan immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the Plan. Neither the Plan nor the *beneficiary* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

RIGHT TO COLLECT NEEDED INFORMATION

The *beneficiary* agrees to cooperate with the *Plan Manager* and assist the *Plan Manager* by:

- Authorizing the release of dental information including the names of all providers from whom *you* received dental attention;
- Obtaining dental information and/or records from any provider as requested by the *Plan Manager*;
- Providing information regarding the circumstances of *your accidental injury*;
- Providing information about other insurance coverage and benefits, including information related to any *accidental injury* for which another party may be liable to pay compensation or benefits; and
- Providing information the *Plan Manager* requests to administer the Plan.

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to an *accidental injury* for which the information is sought, until the necessary information is satisfactorily provided.

Reimbursement/Subrogation Continued

DUTY TO COOPERATE IN GOOD FAITH

The *beneficiary* agrees to cooperate with the *Plan Manager* in order to protect the Plan's recovery rights. Cooperation includes promptly notifying the *Plan Manager* that *you* may have a claim, providing the *Plan Manager* with relevant information, and signing and delivering such documents as the *Plan Manager* reasonably requests to secure the Plan's recovery rights. *You* agree to obtain the Plan's consent before releasing any party from liability for payment of dental expenses. *You* agree to provide the *Plan Manager* with a copy of any summons, complaint or any other process served any lawsuit in which *you* seek to recover compensation for *your accidental injury* and its treatment.

The *beneficiary* agrees to do whatever is necessary to enable the *Plan Manager* to enforce the Plan's recovery rights and will do nothing after loss to prejudice the Plan's recovery rights.

The *beneficiary* agrees not to attempt to avoid the Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Plan Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the Plan's rights will be a material breach of this Plan and will result in the *covered person* being personally responsible to make repayment. In such an event, the Plan may deduct from any pending or subsequent claim made under this Plan any amounts the *covered person* owes the Plan until such time as cooperation is provided and the prejudice ceases.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the Plan.

INCONTESTABILITY

After *you* are covered under this Plan without interruption for two years, the Plan cannot contest the validity of *your* coverage except for nonpayment of premium.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

1. Made in error; or
2. Made to *you* or any party on *your* behalf where the Plan determines the payment to *you* or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against *you* if the Plan has paid *you* or any other party on *your* behalf.

TIME LIMIT ON CERTAIN DEFENSES

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

WORKERS' COMPENSATION NOT AFFECTED

The Plan is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease Act or Law.

WORLDWIDE PROTECTION

This dental Plan pays for reasonable charges anywhere in the world. *Services* will be payable according to the Schedule of Benefits.

WORKERS' COMPENSATION

If benefits are paid by the Plan and the Plan determines *you* received Workers' Compensation for the same incident, the Plan has the right to recover as described under the Reimbursement/Subrogation provision. The Plan will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the *accidental injury* or sickness was sustained in the course of or resulted from *your* employment;
3. The amount of Workers' Compensation due to dental care is not agreed upon or defined by *you* or the Workers' Compensation carrier;

General Provisions Continued

4. The dental care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the Plan, *you* will notify the *Plan Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the Plan as described above.

PRIVACY OF PROTECTED HEALTH INFORMATION

In order for the Plan to operate, it may be necessary from time to time for dental care professionals, the Plan Administrator, individuals who perform Plan-related functions under the auspices of the Plan Administrator, the *Plan Manager* and other service providers that have been engaged to assist the Plan in discharging its obligations with respect to delivery of benefits, to have access to what is referred to as *protected health information*.

A *covered person* will be deemed to have consented to use of *protected health information* about him or her by virtue of enrollment in the Plan. Any individual who may not have intended to provide this consent and who does not so consent must contact the Plan Administrator prior to filing any claim for Plan benefits, as coverage under the Plan is contingent upon consent.

Individually identifiable dental information will only be used or disclosed for purposes of Plan operation or benefits delivery. In that regard, only the minimum necessary disclosure will be allowed. The Plan Administrator, *Plan Manager*, and other entities given access to *protected health information*, as permitted by applicable law, will safeguard *protected health information* to ensure that the information is not improperly disclosed.

Disclosure of *protected health information* is improper if it is not allowed by law or if it is made for any purpose other than Plan operation or benefits delivery. Disclosure for Plan purposes to persons authorized to receive *protected health information* may be proper, so long as the disclosure is allowed by law and appropriate under the circumstances. Improper disclosure includes disclosure to the *employer* for employment purposes, *employee* representatives, consultants, attorneys, relatives, etc. who have not executed appropriate agreements effective to authorize such disclosure.

The *Plan Manager* will afford access to *protected health information* in its possession only as necessary to discharge its obligations as a service provider, within the restrictions noted above. However, Plan records that include *protected health information* are the property of the Plan. Information received by the *Plan Manager* is information received on behalf of the Plan.

The *Plan Manager* will afford access to *protected health information* as reasonably directed in writing by the Plan Administrator, which shall only be made with due regard for confidentiality. In that regard, the *Plan Manager* has been directed that disclosure of *protected health information* may be made to the following person(s):

Attn: Benefits Clerk, Benefits Analyst, Human Resources Director
City of Green Bay
100 North Jefferson Street, Room 500
Green Bay, WI 54301
Telephone No. (920) 448-3147
FAX No. (920) 448-3128

General Provisions Continued

Mortenson, Matzelle & Meldrum, Inc.
3113 West Beltline Highway
P.O. Box 8950
Madison, WI 53708-8950
Telephone No. (608) 273-0655
FAX No. (608) 273-1443

Other City of Green Bay individuals who may be allowed access to *protected health information* include the Mayor, Information Services Director, City Attorney, Deputy City Attorney, Assistant City Attorney, Finance Director, and/or Water Utility Manager. Such employees shall only have access to and use such *protected health information* to the extent necessary to perform the administration functions that the Plan Sponsor performs for the Plan.

Individuals who have access to *protected health information* in connection with their performance of Plan-related functions under the auspices of the Plan Administrator will be trained in these privacy policies and relevant procedures prior to being granted any access to *protected health information*. The *Plan Manager* and other Plan service providers will be required to safeguard *protected health information* against improper disclosure through contractual arrangements.

In addition, *you* should know that the *employer* / Plan Sponsor may legally have access, on an as-needed basis, to limited dental information for the purpose of determining Plan costs, contributions, Plan design, and whether Plan modifications are warranted. In addition, federal regulators such as the Department of Health and Human Services and the Department of Labor may legally require access to *protected health information* to police federal legal requirements about privacy.

Covered persons may have access to *protected health information* about them that is in the possession of the Plan, and they may make changes to correct errors. *Covered persons* are also entitled to an accounting of all disclosures that may be made by any person who acquires access to *protected health information* concerning them and uses it other than for Plan operation or benefits delivery. In this regard, please contact the Plan Administrator.

Covered persons are urged to contact the originating dental care professional with respect to dental information that may have been acquired from them, as those items of information are relevant to dental care and treatment. And finally, *covered persons* may consent to disclosure of *protected health information*, as they please.

CLAIM APPEAL PROCEDURE

You may appeal denial of a claim by following these procedures:

1. File a written request for a full and fair review with the *Plan Manager*;
2. Request to review documents pertinent to the administration of the Plan; and
3. Submit written comments and issues outlining the basis of the appeal.

You may have representation throughout the review procedure. A request for a review must be filed within 60 days after receipt of the written notice or denial of a claim. The full and fair review will be held and a decision rendered by the *Plan Manager* no later than 60 days after receipt of the request. If there are special circumstances, the decision will be made as soon as possible, but no later than 120 days after receipt of the request for review. If such an extension of time is needed, *you* will be notified in writing prior to the beginning of the extension period. The decision after *your* review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decisions are based.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. *You* cannot bring such action more than three years after such proof of loss is made.

DEFINITIONS

Accidental injury means damage to the mouth, teeth, and supporting tissue, due directly to an accident and independent of all other causes. *Accidental injury* does not include damage to the teeth, appliances, or prosthetic devices which results from chewing or biting food or other substances.

Active status means performing on a regular, full-time or part-time basis all customary occupational duties, according to *your* collective bargaining agreement or city policy, at the *employer's* business locations or when required to travel for the *employer's* business purposes. Each day of a regular paid vacation and any regular non-working holiday will be deemed *active status* if *you* were in an *active status* on *your* last regular working day prior to the vacation or holiday.

Beneficiary means *you* and *your* covered *dependent(s)*, or legal representative of either, and anyone to whom the rights of *you* or *your* covered *dependent(s)* may pass.

Calendar year means a period of time beginning on January 1 and ending on December 31.

Cosmetic dentistry means those *services* provided by *dentists* solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

Covered expense means the *maximum allowable fee* or predetermined charge for a *dentally necessary* covered *service* incurred by *you* or *your* covered *dependent(s)*.

Covered person means the *employee* or any of the *employee's* eligible covered *dependents*.

Dentally necessary or dental necessity means the extent of care and treatment which is the generally accepted, proven and established practice by most *dentists* with similar experience and training where the *service* is provided. To determine *dental necessity*, the *Plan Manager* may require preoperative dental x-rays and any other pertinent information to help determine if benefits are payable for the *service* submitted for consideration.

Dentist means an individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental *service* is performed and is operating within the scope of that license.

Dependent means a covered *employee's*:

1. Legally recognized spouse;
2. Unmarried natural blood related child, step-child, legally adopted child, child legally placed for adoption or child for which the *employee* has legal guardianship whose age is less than the limiting age. A child does not mean a foster child. Each child must qualify as a *dependent* on *your* most recently filed Federal Income Tax, or at least be receiving 50% support and maintenance from *you*. If the *dependent* child is a full-time student between ages 19 and 23, the *dependent* child does not have to be claimed on Federal Income Tax or receive at least 50% support and maintenance.

Definition Dependent Continued

The limiting age for each *dependent* child is:

- a. End of the *calendar year* the *dependent* child reaches 19 years of age; or
 - b. End of the *calendar year* the *dependent* child reaches 23 years of age if such child is in regular full-time attendance at an accredited secondary school, college or university. The *dependent* child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A *dependent* child continues to be eligible for coverage for up to four months following the close of a school term. (See Termination of Coverage section on page 17 for details.);
3. A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a qualified medical child support order;
 4. Grandchild, as long as the *employee's* covered *dependent*, who is the parent of the grandchild, is not yet age 18.

You must furnish satisfactory proof to the *Plan Manager* upon request that the above conditions continuously exist. If satisfactory proof is not submitted to the *Plan Manager*, the child's coverage will not continue beyond the last date of eligibility.

A covered *dependent* child who attains the limiting age while covered under the Plan will remain eligible for benefits if all of the following exist at the same time:

1. Mentally retarded or physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a *dependent* as determined by the United States Internal Revenue Service;
4. Declared on and legally qualify as a *dependent* on the *employee's* federal personal income tax return filed for each year of coverage; and
5. Unmarried.

Satisfactory proof of incapacity must be furnished to the *Plan Manager* no later than 31 days after coverage is to terminate. From time to time, the *Plan Manager* may request continued proof of incapacity and dependency, but not more frequently than annually after this waiver of termination has been in effect for two years. If such proof is not submitted within 31 days after the *Plan Manager's* request, the *dependent's* coverage will terminate at the end of the 31-day period.

Emergency means the necessary procedures for treatment of pain and/or injury. *Services* include *emergency* procedures for treatment to the teeth and supporting structures.

Employee means *you*, as an *employee*, when *you* are regularly employed and paid a salary or earnings and are in an *active status* at *your employer's* place of business. Temporary employees (full-time or part-time) are not eligible for coverage under the Plan.

Employer means the sponsor of the Group Plan or any subsidiary(s).

Definitions Continued

Expense incurred means the actual fee charged for an incurred expense by a *covered person*.

Expense incurred date means the date on which:

1. The teeth are prepared for fixed bridges, crowns, inlays, or onlays;
2. The final impression is made for dentures or partials;
3. The pulp chamber of a tooth is opened for root canal therapy;
4. Periodontal surgery is performed;
5. The *service* is performed for *covered expenses* not listed under 1, 2, 3 or 4 above.

Family member means *you* or *your* spouse, or *your* or *your* spouse's child, brother, sister, parent, grandchild or grandparent.

Late applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for dental coverage more than 30 days (31 days after date of marriage) after the eligibility date. If *you* are a *late applicant*, *you* will only have coverage for Preventive *Services* or *services* due to an accident for the first 12 consecutive months *you* are covered under the Plan.

Maximum allowable fee for a *service* means the lesser of:

1. The fee most often charged in the geographical area where the *service* was performed;
2. The fee most often charged by the provider;
3. The fee which is recognized as reasonable by a prudent person;
4. The fee determined by comparing charges for similar *services* to a national data base adjusted to the geographical area where the *services* or procedures were performed; or
5. The fee determined by using a national relative value scale. Relative value scale means a methodology that values medical procedures and *services* relative to each other that includes, but is not limited to, a scale in terms of difficulty, work, risk, as well as the material and outside costs of providing the *service*, as adjusted to the geographic area where the *services* or procedures were performed.

Maximum benefit means the maximum amount that may be payable for each *covered person*, for *expense incurred*. The applicable *maximum benefit* is shown on the Schedule of Benefits. No further benefits are payable once the *maximum benefit* is reached.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

Definitions Continued

Plan Manager means HumanaDental Insurance Company (HDIC). The *Plan Manager* provides services to the Plan Administrator, as defined under the Plan Management Agreement. The *Plan Manager* is not the Plan Administrator or the Plan Sponsor.

Plan year means a period of time beginning on the Plan anniversary date of any year and ending on the day before the same date of the succeeding year.

Predetermination of benefits means a review by the *Plan Manager* of a *dentist's* planned treatment and expected charges, including diagnostic charges, prior to the rendering of *services*.

Protected health information means individually identifiable health information about a *covered person*, including: (a) patient records, which includes but is not limited to all health records, *dentist* and provider notes and bills and claims with respect to a *covered person*; (b) patient information, which includes patient records and all written and oral information received about a *covered person*; and (c) any other individually identifiable health information about *covered persons*.

Services means procedures, surgeries, exams, consultations, advice, diagnosis, referrals, treatment, tests, supplies, drugs, devices or technologies.

Timely applicant means an *employee* and/or an *employee's* eligible *dependent* who applies for dental coverage within 30 days (31 days after date of marriage) of the eligibility date.

You and **your** means *you* as the *employee* and any of *your* eligible covered *dependents*, unless otherwise indicated.

Administered by:

**HUMANA
DENTAL**

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Green Bay, WI 54344
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