



GROUP DENTAL PLAN

SOUTHEAST POLK
COMMUNITY SCHOOL DISTRICT

DELTA DENTAL PREMIER®
SUMMARY PLAN DESCRIPTION

CLAIMS ADMINISTERED BY
DELTA DENTAL OF IOWA

Important Caution: A document like this Summary Plan Description *must* be reviewed and prepared by the employer's legal counsel *before* it is adopted by the employer and distributed to its plan participants. In addition to this Summary Plan Description, the employer should prepare and adopt its own separate plan document[s].

INTRODUCTION

Southeast Polk Community School District maintains the Southeast Polk Community School District Group Dental Plan (“the Dental Plan”) for the exclusive benefit of and to provide dental benefits to its eligible, full-time employees, their spouses, and eligible dependents. These benefits, including information about who is eligible to receive benefits, are summarized in this document, which constitutes the summary plan description.

Claims for reimbursement of dental benefits under the Dental Plan are administered by Delta Dental of Iowa (hereafter “Delta Dental”) pursuant to a contract between Southeast Polk Community School District and Delta Dental.

INTERPRETING THIS SUMMARY PLAN DESCRIPTION

It is important that you understand all parts of this Summary Plan Description to get the most out of your benefits. To help make the information easier to understand, we use the words *you* and *your* to refer to you and your eligible family members who have enrolled for coverage under this Dental Plan. In other places, we use the word *participant* to refer to the employee enrolled under the Dental Plan and the words *beneficiary* or *beneficiaries* to refer to the participant's eligible family members who are enrolled under the Dental Plan. The words, *we*, *us*, and *our* refer to Southeast Polk Community School District, the Plan Administrator for your Dental Plan. Finally, the term *Plan Sponsor* refers to your employer or other sponsor of this Dental Plan.

We will interpret the provisions of this Summary Plan Description and determine the answers to all questions that arise under it. Pursuant to a contract with Delta Dental, we have delegated our administrative discretion to initially determine whether you meet the Dental Plan's written eligibility requirements, or to interpret any other term of this Dental Plan. In addition, if any benefit in this Summary Plan Description is subject to a determination of dental necessity and dental appropriateness, Delta Dental will make that factual determination. Our interpretations and determinations and those of Delta Dental are final and conclusive.

To administer your benefits properly, there are certain rules you must follow. Different rules appear in different sections of this Summary Plan Description. We urge you to become familiar with the entire Summary Plan Description.

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GENERAL INFORMATION ABOUT THE DENTAL PLAN

For your convenience, we have listed below certain, basic, plan-identifying information.

Plan Name: Southeast Polk Community School District
Group Dental Plan

Type of Plan: A group health plan

Plan Year: July 1 – June 30

Original Effective Date: July 1, 2007. The Dental Plan has been amended several times since its original effective date.

Plan Sponsor: Southeast Polk Community School District
8379 Northeast University
Pleasant Hill, IA 50327
515-967-4294

Plan Sponsor's Employer
Identification Number: 42-0863054

Plan Administrator: Southeast Polk Community School District
8379 Northeast University
Pleasant Hill, IA 50327
515-967-4294
Attention: Business Manager

Claims Administrator: Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919
1-800-544-0718

Named Fiduciary: Southeast Polk Community School District
8379 Northeast University
Pleasant Hill, IA 50327
515-967-4294

Funding Medium and Type of Plan Administration:
Benefits under the Dental Plan are self-funded by Southeast Polk Community School District and are paid directly out of the company's general assets. There is no insurance policy, trust, or other fund from which benefits are paid. The Dental Plan is self-administered by Southeast Polk Community School District. Pursuant to a contract between Delta Dental and Southeast Polk Community School District, Delta Dental acts as the Claims Administrator for the Dental Plan on behalf of the Plan Administrator. Although claims for reimbursement under the Dental Plan are submitted to Delta Dental for a determination of eligibility, processing, and initial payment, Southeast Polk Community School District, and not Delta Dental, is at all times responsible for payment of all claims under the Plan.

Source of Contributions: Contributions for the Dental Plan are made in part by Southeast Polk Community School District and in part by employees' pre-tax payroll deductions.

Agent for Service of Legal Process: Southeast Polk Community School District
8379 Northeast University
Pleasant Hill, IA 50327
515-967-4294

Legal Plan Document & Disclaimer: This Summary Plan Description summarizes the principal features of the Dental Plan in a general manner. The complete terms and conditions of the Dental Plan are contained in the Group Dental Plan legal document adopted by Southeast Polk Community School District and in portions of this Summary Plan Description. You can obtain a copy of the Group Dental Plan legal document from the Plan Administrator.

SUMMARY OF BENEFITS AND PAYMENT

The information on this page summarizes your benefits and payment obligations. For a detailed description of specific benefits and benefit limitations, see the IMPORTANT INFORMATION and BENEFITS sections of this Summary Plan Description.

If a dollar amount for a deductible, benefit period maximum or lifetime maximum is shown at the top of the chart and applies to a benefit category, “Yes” will be indicated across from that category. If the information does not apply it will indicate “Waived” or be left blank. If there is unique information for a specific benefit it will appear across from that benefit.

Delta Dental Premier[®]	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Benefit Categories	\$25/\$50		\$1,000	\$1,500
Check-Ups and Teeth Cleaning (Diagnostic and Preventive Services) <ol style="list-style-type: none"> 1. Dental Cleaning 2. Oral Evaluation 3. Fluoride Applications 4. X-rays 	Waived	00%	Yes	
Cavity Repair and Tooth Extractions (Routine and Restorative Services) <ol style="list-style-type: none"> 1. Emergency Treatment 2. General Anesthesia/Sedation 3. Restoration of Decayed or Fractured Teeth 4. Limited Occlusal Adjustment 5. Routine Oral Surgery 6. Sealant Applications 7. Space Maintainers 8. Posterior Composites 	Yes	20%	Yes	

	DEDUCTIBLE	COINSURANCE	BENEFIT PERIOD MAX	LIFETIME MAX
Root Canals (Endodontic Services) <ol style="list-style-type: none"> 1. Apicoectomy 2. Direct Pulp Cap 3. Pulpotomy 4. Retrograde Fillings 5. Root Canal Therapy 	Yes	20%	Yes	
Gum and Bone Diseases (Periodontal Services) <ol style="list-style-type: none"> 1. Conservative Procedures 2. Complex Procedures 3. Maintenance Therapy 	Yes	20%	Yes	
High Cost Restorations (Cast Restorations) <ol style="list-style-type: none"> 1. Cast Restorations <ol style="list-style-type: none"> a. Crowns b. Inlays c. Onlays d. Posts and Cores 	Yes	50%	Yes	
Dentures and Bridges (Prosthetics) <ol style="list-style-type: none"> 1. Bridges 2. Bridge Repairs 3. Dentures 4. Dental Implants 	Yes	50% 20% 50% 50%	Yes	
Straighter Teeth (Orthodontics)	Yes	50%		Yes

DENTAL PLAN

ADMINISTRATION

The administration of the Dental Plan is under the supervision of the Plan Administrator, Southeast Polk Community School District. The Business Manager of Southeast Polk Community School District is the person who acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the terms of the Dental Plan are carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Company bears all costs of administering the Plan and for paying all claims.

Under a contract with Delta Dental, the Plan Administrator has delegated its authority to Delta Dental to act as the Claims Administrator for the Dental Plan and to determine the initial eligibility for and the amount of any benefits payable under the Dental Plan and for prescribing the procedures to be followed and the forms to be used by you pursuant to the Dental Plan. We have further delegated to Delta Dental, as the Claims Administrator, the authority to require you to furnish it with such information as it determines is necessary for the proper administration of the Dental Plan. If you have general questions regarding the Dental Plan, please contact the Plan Administrator. However, if you have specific questions concerning eligibility for and/or the amount of any benefits payable under the Dental Plan, please contact Delta Dental.

7 IMPORTANT INFORMATION

Delta Dental of Iowa is the Claims Administrator of your Delta Dental Premier Dental Plan. By encouraging preventive care, this dental program is designed to help contain dental costs. The key component of Delta Dental Premier program is its panel of *participating dentists*, hereafter referred to as Delta Dental dentists. You may seek care from almost any dentist you wish. However, there are advantages when you receive services from Delta Dental dentists.

Your payment responsibilities are also outlined in this section of your Summary Plan Description. How much you pay for covered services depends on the benefit category of the service you receive and the dentist you receive services from. It is most often to your financial advantage to receive services from a Delta Dental dentist.

WHAT YOU SHOULD KNOW ABOUT DELTA DENTAL DENTISTS

Delta Dental has contract relationships with Delta Dental dentists throughout the state. Delta Dental's contracts with dentists include payment arrangements that are made possible by its broad base of customers. Delta Dental uses different methods to determine payment arrangements. These payment arrangements usually result in savings. When you receive services from dentists who participate with Delta Dental of Iowa or any other Delta Dental Plan, all of the following statements are true:

- Delta Dental dentists agree to accept their local Delta Dental's payment arrangements, which may result in savings.
- Delta Dental dentists agree to file claims for you.
- Delta Dental settles claims directly with Delta Dental dentists. You are responsible for any deductible and coinsurance amounts you may owe. See UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS later in this section.
- Delta Dental dentists agree to handle the notification program for you, see THE NOTIFICATION PROGRAM section.

WHAT YOU SHOULD KNOW ABOUT DENTISTS WHO DO NOT PARTICIPATE WITH DELTA DENTAL

When you receive services from nonparticipating dentists, you will not receive any of the advantages of Delta Dental contracts with Delta Dental dentists. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- Delta Dental does not have contract relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental's payment arrangements. This means you are responsible for any difference between your nonparticipating dentist's covered charge and the Maximum Plan Allowance (Delta Allowance). See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- Delta Dental settles claims with you, not nonparticipating dentists. You are responsible for paying your dentist in full, including any deductible, coinsurance and non-approved charges you may owe. See UNDERSTANDING PAYMENT VOCABULARY later in this section.
- Nonparticipating dentists do not agree to handle the notification program for you. See THE NOTIFICATION PROGRAM.
- Nonparticipating dentists may charge for "infection control," which includes the costs for services and supplies associated with sterilization procedures. You are responsible for any extra charges billed by a nonparticipating dentist for "infection control." (All dentists are legally required to follow certain guidelines to protect their patients and staff from exposure to infection. However, Delta Dental dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")

QUESTIONS DELTA DENTAL ASKS WHEN YOU RECEIVE DENTAL CARE

Even though a procedure may appear in a given section such as BENEFITS, you should note that before you are eligible to receive benefits, Delta Dental first answers all of the following questions:

Is the Procedure Dentally Necessary?

All of the following must be true for a procedure to be considered dentally necessary:

- The diagnosis is proper.
- The treatment is necessary to preserve or restore the form and the function of the tooth or teeth and the health of the gums, bone, and other tissues supporting the teeth.

Is the Procedure Dentally Appropriate?

All of the following must be true for a procedure to be considered dentally appropriate:

- The treatment is the most appropriate procedure for your individual circumstances.
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by Delta Dental.
- The treatment is not more costly than alternative procedures that would be equally effective for the treatment or maintenance of your teeth and their supporting structures. **If you receive alternative services other than the least costly, you are responsible for paying the difference.**

Is the Procedure Subject to Benefit Limitations?

Benefit limitations refer to amounts that are your liability based on the terms of the Dental Plan. Examples of benefit limitations include all of the following:

- Amounts for procedures that are not dentally necessary or dentally appropriate.
- Amounts for procedures that are not covered by this Summary Plan Description. See SERVICES NOT COVERED.
- Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered twice per benefit period. More frequent teeth cleaning is not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See BENEFITS for a description of covered procedures and limitations associated with certain procedures.
- Amounts for procedures that have reached contract benefit maximums. See the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Summary Plan Description.
- Any difference between the covered charge and the Maximum Plan Allowance (Delta Allowance). **Please note:** This only applies if you receive services from a nonparticipating dentist.

DELTA DENTAL'S PAYMENT POLICY

Delta Dental's policy is to send payment for treatment after it is completed—not before.

For example, Delta Dental will send payment for:

- a crown when it is seated.
- a fixed or removable prosthesis when it is inserted.
- a root canal when it is filled.

UNDERSTANDING PAYMENT VOCABULARY

Benefit Period

A benefit period is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1. This is true for as long as you have coverage.

The benefit period is important for calculating your deductible and benefit period maximum, if applicable.

Billed Charge

The billed charge is the amount a dentist bills for a specific dental procedure.

Covered Charge

The covered charge is the amount a dentist bills for a dental procedure *that is a benefit of your Dental Plan*.

HOW WAITING PERIODS AFFECT BENEFIT PAYMENTS

WAITING PERIOD

A waiting period is the amount of time you and your family member(s) must wait before certain benefits are available under this certificate.

Waiting periods apply when:

- you, the plan member, initially decline coverage for yourself or your family members and later enroll.
- you cancel this dental coverage, for whatever reason and decide to reenroll at a later time.
- you change who is covered under this dental coverage and decide to reenroll them at a later time.

Single Coverage. If you initially decline coverage or you have single coverage and decide to cancel your dental plan:

- you may not elect or re-elect coverage until a subsequent anniversary date of the contract between us and your employer and
- when you elect or re-elect coverage, benefits will be limited to Benefit Categories: Check-Ups and Teeth Cleaning, Cavity Repair and Tooth Extractions, Root Canals and Gum and Bone Diseases for 12 consecutive months. After you satisfy this 12-month waiting period, you will be eligible to receive full coverage.

Family Coverage. If you, the plan member, initially decline coverage or you have family coverage and decide to change your dental plan to single coverage:

- You may not elect or re-elect family coverage until a subsequent anniversary date of the contract between us and your employer; and
- If you elect or re-elect family coverage, benefits for family members other than you –the plan member - will be limited to Benefit Categories: Check-Ups and Teeth Cleaning, Cavity Repair and Tooth Extractions, Root Canals and Gum and Bone Diseases for 12 consecutive months. After family members satisfy the 12-month waiting period, they will be eligible to receive full coverage.

If you, the plan member, initially decline coverage or you have family coverage and decide to cancel your dental plan for the entire family, the following will take place:

- you may not elect or re-elect single coverage or family coverage until a subsequent anniversary date of the contract between us and your employer; and

- if you elect or re-elect single or family coverage, benefits will be limited to Benefit Categories: Check-Ups and Teeth Cleaning, Cavity Repair and Tooth Extractions, Root Canals and Gum and Bone Diseases for 12 consecutive months. After you satisfy this 12-month waiting period, you are then eligible to receive full coverage.

Maximum Plan Allowance (Delta Allowance)

Maximum Plan Allowance is the amount which equals the lesser of the covered charge for a service, supply, or any dental procedure covered under the Dental Plan or an amount which Delta Dental establishes annually as its maximum allowable fee for the same service or supply.

For all dental procedures covered under the plan, the maximum allowable fee is established by Delta Dental of Iowa for a covered dental procedure that is dentally necessary and dentally appropriate. It is developed from various sources, such as contracts with dentists, input from Delta Dental dental consultants, the simplicity or complexity of the procedure, and the billed charge for the same procedures by dentists in Iowa.

For services billed by dentists outside of Iowa, the maximum allowable fee is based on information from that state's Delta Dental Plan.

UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

Deductible

A deductible is the fixed dollar amount you pay for covered services in a benefit period before benefits are available under this Dental Plan. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Summary Plan Description. **Please note:** The family deductible is reached from deductible amounts paid on behalf of any combination of members.

Coinsurance

Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive certain covered services. These amounts are shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Summary Plan Description.

Coinsurance payments begin once you meet any applicable deductible amounts. Coinsurance is calculated off the Maximum Plan Allowance (Delta Allowance). In general, the percentage of coinsurance you pay depends on the benefit category of the service you receive.

Benefit Period Maximum

The benefit period maximum is the maximum benefit each member is eligible to receive for certain covered services in a benefit period. The benefit period maximum is reached from claims settled under this Summary Plan Description in a benefit period. This amount is shown on the SUMMARY OF BENEFITS AND

Services received from BENEFIT CATEGORY: STRAIGHTER TEETH are excluded from your benefit period maximum.

Lifetime Maximum

In a participant's or beneficiary's lifetime, total benefits are limited by dollar amount for BENEFIT CATEGORY: STRAIGHTER TEETH. This amount is shown on the SUMMARY OF BENEFITS AND PAYMENT chart at the beginning of this Summary Plan Description.

HELPING WHEN YOU HAVE QUESTIONS

If you have any questions after reading this Summary Plan Description, please call Delta Dental. For your convenience, Delta Dental has listed their toll-free number on the back cover of this Summary Plan Description.

BENEFITS

CHECK-UPS AND TEETH CLEANING DIAGNOSTIC AND PREVENTIVE SERVICES

Dental Cleaning (Prophylaxis)

Removing plaque, tartar (calculus), and stain from teeth.

Limitation: Dental cleaning is a benefit only twice per benefit period.

Oral Evaluations

Limitation: This evaluation is a benefit only twice per benefit period.

Topical Fluoride Applications

Limitation: Topical fluoride is a benefit only for unmarried beneficiaries who are dependent children under age 19 once every 12 consecutive months.

X-Rays:

Bitewing X-Rays

Limitation: These x-rays are a benefit only once every 12 consecutive months.

Full-Mouth X-Rays

Full-mouth x-rays include a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date.

A panoramic x-ray is a benefit if full-mouth x-rays have not been performed within 5 consecutive years of the panoramic x-ray.

Limitation: Full-mouth x-rays are a benefit only once every 5 consecutive years.

Occlusal and Extraoral X-Rays

Limitation: These x-rays are a benefit only once every 12 consecutive months.

Periapical X-Rays

Sealant Applications

Filling decay-prone areas of the chewing surface of molars.

Limitation: Sealant applications are a benefit:

once per permanent first and second molars for eligible beneficiaries who are dependent children under age 15.

Sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration are not a benefit.

Space Maintainers for Missing Back Teeth

Limitation: Space maintainers are a benefit only for eligible dependent children under age 15.

CAVITY REPAIR AND TOOTH EXTRACTIONS ROUTINE AND RESTORATIVE SERVICES

Emergency Treatment (Palliative Treatment)

Treatment to relieve pain or infection of dental origin.

General Anesthesia/Sedation

Limitation: General anesthesia and intravenous sedation are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.

Restoration of Decayed or Fractured Teeth

Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings.

Limited Occlusal Adjustment

Reshaping the biting surfaces of one or more teeth.

Limitation: Limited Occlusal Adjustment is a benefit only twice every 12 consecutive months.

Limitation: You are not covered for Complete Occlusal Adjustment, a more complex procedure which requires several appointments and is intended to revise or alter the functional relationships between upper and lower teeth.

Routine Oral Surgery

Including removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin.

ROOT CANALS ENDODONTIC SERVICES

Apicoectomy/Periradicular Surgery

Surgery to repair a damaged root as part of root canal therapy or to correct a previous root canal.

Direct Pulp Cap

Covering exposed pulp with a dressing or cement to protect it and promote healing and repair. *Treatment of pulp that is not exposed (indirect pulp cap) is not a benefit.*

Pulpotomy

Removing the coronal portion of the pulp as part of root canal therapy. When performed on a baby (primary) tooth, pulpotomy is the only procedure required for root canal therapy.

Retrograde Fillings

Sealing the root canal by preparing and filling it from the root end of the tooth.

Root Canal Therapy

Treating an infected or injured pulp to retain tooth function. This procedure generally involves removal of the pulp and replacement with an inert filling material.

GUM AND BONE DISEASES PERIODONTAL SERVICES

Please note: Procedures in this category should receive Delta Dental's review *before* they are performed. See THE NOTIFICATION PROGRAM.

Full Mouth Debridement

Limitation: Full mouth debridement is a benefit once in a lifetime.

Conservative Periodontal Procedures (Root Planing and Scaling)

Removing contaminants such as bacterial plaque and tartar (calculus) from a tooth root to prevent or treat disease of the gum tissues and bone which support it.

Limitation: Conservative periodontal procedures are a benefit only once every 24 consecutive months for each quadrant of the month.

Complex Periodontal Procedures

Various surgical interventions designed to repair and regenerate gum and bone tissues that support the teeth.

Limitation: Complex periodontal procedures are a benefit only once every 5 consecutive months for each quadrant of the mouth for natural teeth only.

Note: A quadrant is one of the four equal sections of the mouth into which the jaws can be divided and represents four or more contiguous teeth or bounded teeth spaces.

Periodontal Maintenance Therapy

Includes various maintenance services such as pocket depth measurements, dental cleaning (oral prophylaxis), removal of stain, and root planing and scaling.

Limitation: This procedure must follow conservative or complex periodontal therapy. When this procedure immediately follows complex or conservative periodontal therapy, benefits are available up to four times in the first benefit period and twice per benefit period thereafter. *This procedure replaces the dental cleaning benefit (prophylaxis) described under Check-Ups and Teeth Cleaning earlier in this section.*

HIGH COST RESTORATIONS CAST RESTORATIONS

Procedures in this category are available once every 5 consecutive years beginning from the date the cast restoration is cemented in place.

Cast Restorations for Complicated Tooth Decay or Fracture

Restoring a tooth with a cast filling (including local anesthesia) when the tooth cannot be restored with a silver (amalgam) or tooth-colored (composite) filling.

Crowns

Restoring form and function by covering and replacing the visible part of the tooth with a precious metal, porcelain-fused-to-metal, or porcelain crown. *Crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition and abrasion are not a benefit.* *Limitation:* Crowns are a benefit only if the tooth cannot be restored with a routine filling.

Inlays

Restoring a tooth with a cast metallic or porcelain filling.

Onlays

Replacing one or more missing or damaged biting cusps of a tooth with a cast restoration.

Posts and Cores

Preparing a tooth for a cast restoration after a root canal when there is insufficient strength and retention.

Recementation of Cast Restorations

Limitation: Benefits are limited to once every 12 consecutive months after 6 months have elapsed since initial placement.

**DENTURES AND BRIDGES
PROSTHETICS**

Please note: Dentures and bridges (prosthetics) are a benefit once every 5 consecutive years.

Bridges

Replacing missing permanent teeth with a dental prosthesis that is cemented in place and can only be removed by a dentist. Also covered are bridge repairs.

Dentures (Complete and Partial)

Replacing missing permanent teeth with a dental prosthesis that is removable. Denture repair and relining are also covered.

Dental Implants

Dental Implants which are surgically placed in the jaw bone, including attachment of devices to a surgically placed implant in the jaw.

Denture Adjustments

Limitations: Denture Adjustments will be limited to two per denture per benefit period after 6 months has elapsed since initial placement.

Tissue Conditioning

Limitation: Tissue conditioning will be limited to two per denture every 36 consecutive months.

STRAIGHTER TEETH

ORTHODONTICS

Orthodontics. Services for proper alignment of teeth.

Limitation: Orthodontic services for proper alignment of teeth are a benefit only for beneficiaries who are unmarried, dependent children under age 19.

When an orthodontic treatment plan is established, Delta Dental of Iowa will calculate an initial payment at the time the banding takes place. The balance of the allowed fee will then be divided into monthly payments over the course of treatment, providing dental benefits still exist.

If orthodontic treatment is stopped for any reason before it is completed, payment will be provided only for covered services and supplies actually received.

No benefits are available for charges made after treatment stops or after the termination of dental benefits.

Payment for treatment in progress extends only to the months of treatment received while covered under the plan. Delta Dental of Iowa will determine the months eligible for dental benefits.

Diagnostic Cast

Limitation: Diagnostic cast is a benefit only in conjunction with orthodontic treatment.

SERVICES NOT COVERED

This *Dental Plan* does not provide benefits for dental treatment listed in this section. **Please note:** Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Dental Plan. Call Delta Dental if you are unsure if a certain service is covered. For your convenience, Delta Dental has listed its toll-free number on the back cover of this Summary Plan Description.

EXCLUSIONS

Anesthesia or Analgesia

You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure. This exclusion does not apply to general anesthesia or intravenous sedation administered in connection with covered oral surgery as described in BENEFITS.

Broken Appointments

You are not covered for any fees charged by your dental office because of broken appointments.

Complete Occlusal Adjustment

You are not covered for services or supplies used for revision or alteration of the functional relationships between upper and lower teeth. However, you are covered for limited occlusal adjustment, a less complex procedure to reshape the biting surfaces of one or more teeth.

Complications of a Non-Covered Procedure

You are not covered for complications of a non-covered procedure.

Congenital Deformities

You are not covered for services or supplies to correct congenital deformities, such as a cleft palate.

Controlled Release Device

You are not covered for services or supplies used for the controlled release of therapeutic agents into diseased crevices around your teeth.

Cosmetic in Nature

You are not covered for services or supplies which have the primary purpose of improving the appearance of your teeth, rather than restoring or improving dental form or function.

Crowns Not Meant to Restore Form and Function

You are not covered for crowns that are not meant to restore form and function of a tooth, including crowns placed for the primary purpose of periodontal splinting, cosmetics, altering vertical dimension, restoring your bite (occlusion), or restoring a tooth due to attrition, abrasion, erosion and abfraction.

Desensitization Material

You are not covered for desensitization materials or their application.

Drugs

You are not covered for prescription, non-prescription drugs, medicines or therapeutic drug injections.

Effective Date

You are not covered for services or supplies received before the effective date of your coverage under this Dental Plan.

Experimental or Investigative

You are not covered for services or supplies that are considered experimental, investigative or have a poor prognosis. Peer reviewed outcomes data from clinical trials, Food and Drug Administration regulatory status, and established governmental and professional guidelines will be used in this determination.

Government Programs

You are not covered for services or supplies when you are entitled to claim benefits from governmental programs (except Medicaid).

Guided Tissue Regeneration

You are not covered for services or supplies to encourage regeneration of lost periodontal structures.

Incomplete Services

You are not covered for dental services that have not been completed.

Indirect Pulp Caps

You are not covered for indirect pulp caps.

Infection Control

You are not covered for *separate* charges for “*infection control*,” which includes the costs for services and supplies associated with sterilization procedures. *Delta Dental* dentists incorporate these costs into their normal fees and will not charge an additional fee for “*infection control*.”

Lost or Stolen Appliances

You are not covered for services or supplies required to replace lost or stolen dental appliances.

Medical Services or Supplies

You are not covered for services or supplies which are medical in nature, including dental services performed in a hospital, treatment of fractures and dislocations, treatment of cysts and malignancies, and accidental injuries.

Military Service

You are not covered for services or supplies which are required to treat an illness or injury received while you are on active status in the military services.

Orthodontics for Adults

You are not covered for adult orthodontics.

Payment Responsibility

You are not covered for services or supplies when someone else has the legal obligation to pay for your care, and when, in the absence of this Dental Plan, you would not be charged.

Periodontal Appliances

You are not covered for services or supplies for periodontal appliances (bite guards) to reduce bite (occlusal) trauma due to tooth grinding or jaw clenching.

Periodontal Splinting

You are not covered for services or supplies used for the primary purpose of reducing tooth mobility, including crown-type restorations.

Provisional Crowns, Bridges or Dentures

You are not covered for services or supplies for provisional crowns, bridges or dentures.

Repair, Replacement or Duplication of Orthodontic Appliances

You are not covered for services or supplies required to repair, replace or duplicate any orthodontic appliance.

Sealants for Primary Teeth, Wisdom Teeth, or Restored Teeth

You are not covered for sealants for primary teeth, wisdom teeth, or teeth that have already been treated with a restoration.

Services Provided in Other Than Office Setting

You are not covered for services provided in other than a dental office setting.

Specialized Services

You are not covered for specialized, personalized, elective materials and techniques or technology which are not reasonably necessary for the diagnosis or treatment of dental disease or dysfunction. Specialized services represent enhancements to other services and are considered optional.

Temporary or Interim Procedures

You are not covered for temporary or interim procedures.

Temporomandibular Joint Dysfunction (TMD)

You are not covered for expenses incurred for diagnostic x-rays, appliances, restorations or surgery in connection with Temporomandibular Joint Dysfunction (TMD) or myofunctional therapy.

Termination

Whether or not Delta Dental has approved a treatment plan, you are not covered for treatment received after the date your coverage terminates.

Treatment By Other Than A Licensed Dentist

You are not covered for services or treatment performed by other than a licensed dentist or his or her employees.

Unerupted Teeth

You are not covered for the prophylactic removal of unerupted teeth (asymptomatic and nonpathological). This means we will not pay for the removal of any tooth that is not visible and not causing harm.

Workers' Compensation

You are not covered for services or supplies that are or could have been compensated under Workers' Compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's Workers' Compensation coverage.

THE NOTIFICATION PROGRAM

This section explains the notification program you or your Delta Dental dentist should follow before you receive certain benefits available under this Dental Plan. This program is the checks and balances of your dental coverage. It helps:

- determine that services are dentally necessary and dentally appropriate;
- confirm the benefits of your Dental Plan.

THE APPROVAL

The purpose of the notification program is to help control the cost of your benefits — not to keep you from receiving dentally necessary and dentally appropriate treatment.

You should notify Delta Dental before you receive the following benefits:

Gum and Bone Diseases

You should also notify Delta Dental before you receive treatment from any benefit category that will exceed \$300.

Delta Dental's review is based on the treatment plan submitted by your dentist.

THE TREATMENT PLAN

A treatment plan describes the treatment your dentist has recommended for you and helps Delta Dental determine if the procedure is a benefit of your Dental Plan as well as dentally necessary and dentally appropriate.

When to Submit a Treatment Plan

You will need to file a treatment plan only if your dentist is nonparticipating — Delta Dental dentists agree to file for you.

A complete treatment plan includes the plan of treatment and x-rays. Please send the x-rays within 15 working days of receipt of the proposed treatment plan.

Where to Send a Treatment Plan

Submit the proposed treatment plan, along with x-rays and supporting information to:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919*

THE TREATMENT PLAN REVIEW

Once Delta Dental receives the treatment plan and proper documentation, Delta Dental will let you and your dentist know if the treatment plan is approved within 15 working days. Delta Dental will take one of the following three actions when they receive your treatment plan:

- *accept* it as submitted.
- *recommend an alternative benefit*. If Delta Dental asks you to receive an independent diagnosis from a dentist of Delta Dental's choice, Delta Dental will pay for the exam.
- *deny the treatment plan* because:
 - the procedure is not a benefit of this Dental Plan;
 - you did not receive an independent exam after Delta Dental asked you to; or
 - the procedure is not dentally necessary and dentally appropriate.

Appeal

If Delta Dental denies a treatment plan, you can resubmit it with additional documentation and ask Delta Dental, in writing, to reconsider. If necessary, Delta Dental will ask you to receive an independent diagnosis from an independent dentist of Delta Dental's choice—Delta Dental will pay for the exam.

Please note: Although Delta Dental may approve a treatment plan, neither Delta Dental nor this Dental Plan are necessarily liable for the actual treatment you receive from your dentist.

FILING CLAIMS

Once you receive dental services, Delta Dental needs to receive a claim to determine the amount of your benefits. The claim lets Delta Dental know the services you received, when you received them, and from which dentist. You will need to file a claim only when you use a nonparticipating dentist who does not agree to file a claim for you —Delta Dental dentists file for you.

WHEN TO FILE YOUR CLAIM

After you receive services, you should file a claim only if your dentist has not filed one for you. Delta Dental may disallow payment of a claim submitted more than 365 days after the date services were rendered.

You should file a claim only *after* the procedure is completely finished. Do not file for payment before a procedure is completed.

If you need a claim form or have any questions after reading this section, please call us or visit our website www.deltadentalia.com. For your convenience, we have listed our toll-free number on the back cover of this certificate. If you must file your own claim, send it to the following address:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919*

FILING WHEN YOU HAVE OTHER COVERAGE COORDINATION OF BENEFITS

You may have other insurance or coverage that provides the same or similar benefit(s) as this Dental Plan. If so, Delta Dental will work with your other insurance company or carrier or health plan. The benefits payable under this Dental Plan when combined with the benefits paid under your other coverage will not be more than 100 percent of either Delta Dental's payment arrangement amount or the other carrier's or health plan's payment arrangement amount.

What You Should Do

When you receive services, you need to let Delta Dental know that you have other coverage. Other coverage includes: group insurance, other group benefit plans (such as HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no-fault basis). To help Delta Dental coordinate your benefits, you should:

- inform your dentist by giving him or her information about your other coverage at the time you receive services. Your dentist will pass the information on to Delta Dental when the claim is filed.
- indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. Delta Dental will contact you if it needs any additional information.

You must cooperate with Delta Dental and provide requested information about your other coverage. If you do not give Delta Dental necessary information, your claims will be denied.

What Delta Dental Will Do

There are certain rules Delta Dental follows to help determine which coverage pays first when you have other insurance or coverage that provides the same or similar benefits as this Dental Plan. Here are some of the rules:

- The coverage *without coordination of benefits* pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The dental benefits of your *auto coverage* will pay before this coverage if the auto coverage does not have a coordination of benefits provision.
- The coverage which you have as *an employee or plan member* participant pays before the coverage which you have as a plan beneficiary spouse or dependent child.
- The coverage you have as *the result of your active employment* pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the *earliest continuous effective date* pays first when none of the above rules apply.

(If none of the guidelines just mentioned apply to your situation, Delta Dental will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine our payment to you.)

What You Should Know About Beneficiaries Who Are Dependent Children

To coordinate benefits for a dependent child the following rules apply. For a child who is:

- *covered by both parents* who are not separated or divorced or if they are, neither parent has primary physical custody, the coverage of the parent whose birthday occurs first in a calendar year pays first. If another carrier does not use this rule, then the other plan will determine which coverage pays first.
- *covered by separated or divorced parents* and a court decree says which parent has financial or dental insurance responsibility, that parent's coverage pays first.
- *covered by separated or divorced parents* and a court decree does not stipulate which parent has financial or dental insurance responsibility, then the coverage of the parent with custody pays first. The payment order for this dependent child is as follows: custodial parent, spouse of custodial parent, other parent, and spouse of other parent.

If none of these rules apply, the parent's coverage with the earliest continuous effective date pays first.

DENIED CLAIMS AND APPEALS PROCEDURES

CLAIM DENIALS

Pursuant to our contract with Delta Dental, we have delegated the responsibility for evaluating all claims for reimbursement to Delta Dental as the Claims Administrator. Delta Dental will decide your claim within a reasonable time not longer than 30 days after it is received. This time period may be extended, however, where a claim is incomplete or there are other circumstances beyond Delta Dental's control. In such a case, Delta Dental will provide you with written notice of any required extension in the time for them to respond, including the reasons for such an extension and information on the date on which a decision is expected to be made. If an extension is necessary because a claim is incomplete, the written notice to you will also request that you provide Delta Dental with certain additional information within 45 days. The time period for Delta Dental to respond to your claim can be extended for an additional 15 days from the date on which Delta Dental receives the requested additional information.

Delta Dental may obtain the advice of independent dentists or require such other evidence as it deems necessary to decide your claim.

If Delta Dental denies your claim, in whole or in part, you will be furnished with a written notice setting forth the following information:

1. the specific reasons for the denial;
2. reference to the specific provisions of the Dental Plan on which the denial is based;
3. a description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
4. appropriate information as to the steps to be taken if you wish to appeal the decision of Delta Dental, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information.

APPEALING DENIED CLAIMS

If you disagree with Delta Dental's reasons for not paying all or part of your claim and think that the service should be covered under this Dental Plan, you or your representative can appeal by asking for a full and fair review of the claim. To file for a review, you must submit a request in writing within 180 days of receiving Delta Dental's notice that it is denying your claim. If you do not submit a request for review within this time period, you will lose your right to review and you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative review rights, which is generally a prerequisite to bringing suit.

Your request for a review should state the reasons why you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) all documents, records, and other information relevant to your claim and its review. Delta Dental will review all written comments that you submit with your request. Upon request, you can review the records of Delta Dental that are relevant to your claim from 8 a.m. to 4:30 p.m., Central Time, Monday through Friday, at Delta Dental's Ankeny, Iowa location.

Since Delta Dental maintains many of these records in electronic form, please call or write Delta Dental in advance so they can have paper copies of these records available for your review.

Send your request to:

*Delta Dental of Iowa
P.O.Box 919
Ankeny, IA 50021-0919
or call 1-800-544-0718*

Delta Dental will review your request and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that person's subordinate. Delta Dental may secure the advice of independent dentists or others and require such evidence as it deems necessary to decide your appeal, except that any dental or other expert consulted in connection with your appeal will be different from any expert consulted in connection with your initial claim. The identity of any dental or other expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be given a notice of denial on review that provides the following information:

1. the specific reason(s) for the denial;
2. the specific provisions of the Dental Plan on which the decision is based;
3. a statement of your right to review (on request and at no charge) relevant documents and other information;
4. if Delta Dental relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request.

ELIGIBILITY

COVERAGE ELIGIBILITY

You are eligible to be a participant in the Dental Plan if you are an employee who has met your employer's eligibility requirements or if you are either the spouse or an eligible dependent child of an employee who has met the employer's eligibility requirements.

Spouse means your husband or wife as the result of a marriage that is legally recognized in Iowa, Common Law Spouses or Domestic Partners. An eligible dependent child can be your natural child, a child placed with you for adoption or a legally adopted child, a child for whom you have legal guardianship, a stepchild, or a foster child. To be a beneficiary, a dependent child must meet the following requirements:

- The child is *not married* and either under 25 years of age or a full-time student. A full-time student is a dependent claiming status as a full-time student. The dependent must be enrolled in an accredited institution of higher learning, such as a college, university, nursing school, or trade school, and carry 12 or more hours per semester. Full-time student status continues during regularly scheduled school vacation periods; and during absence from class in which enrolled for up to four months due to a physical or mental disability. The disability must be substantiated by a written statement from a physician.
- The child is totally and permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 25 or while the child was a full-time student, and the dependent must have had continuous qualifying dental coverage without a break of 63 days or more since the child turned age 25 or while the child was a full-time student.

A dependent child who has been placed in your home for the purpose of adoption or who you have adopted shall be eligible for coverage as of the date of placement for adoption or as of the date of actual adoption, whichever occurs first.

COMMON LAW SPOUSES/DOMESTIC PARTNERS

Coverage is provided for common law spouses/domestic partners. To obtain coverage for your common law spouse/domestic partner you and your common law spouse/domestic partner must meet the following conditions and attest to this by completing and signing an affidavit stating that a common law marriage/domestic partnership exists.

- You and your common law spouse/domestic partner must be in a committed and mutually exclusive relationship in which you are jointly responsible for each other's welfare and financial obligations.
- You and your common law spouse/domestic partner must have resided together in the same principal residence for at least twelve months and intend to do so indefinitely.
- If you were previously married, one year has elapsed since the effective date of your divorce.
- You and your common law spouse/domestic partner must be eighteen years of age or older, unmarried, and not blood relatives.

If you and your common law spouse/domestic partner no longer meet the criteria listed above, you must complete an affidavit stating the common law marriage/domestic partnership has terminated. Coverage will terminate on the last day of the month that the common law marriage/domestic partnership ends. Failure to request coverage termination for an ineligible common law spouse/domestic partner in a timely manner will require you to repay any subsidy paid by the school district for the common law spouse's/domestic partner's coverage once they were deemed ineligible. You may not file another common law/domestic partnership affidavit after filing a notification of common law/domestic partnership termination for at least twelve months. Please contact the Human Resources department for assistance in completing the appropriate forms. These guidelines apply to both same-sex and opposite-sex domestic partners.

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for dental coverage if he/she is a regular full-time employee who is scheduled to work thirty (30) or more hours each week. If the employee ceases to work, or is no longer scheduled to work thirty (30) or more hours a week he/she ceases to be a covered employee under this Plan.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

If an employee is hired effective the first of the month or on the first of the month and eligible, this Plan is effective on the first of the month, providing he/she enrolls for coverage within thirty-one (31) days following their employment. If an employee is hired after the first of the month or their effective date is after the first of the month and the employee is eligible, this Plan is effective the first of the following month, providing he/she enrolls for coverage within thirty-one (31) days following their employment.

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled work day.

If the employee does not apply to become a covered employee by completing an enrollment form or application within the 31-day period following their date of employment, he/she will be considered a late enrollee under this Plan and may be subject to a **Late Entrant Waiting Period**. This Plan will be effective on the first day of the month following receipt of the employee's enrollment form or application.

In some cases, there may be "special" circumstances that will allow an employee to enroll for coverage without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered employee who elects to become a covered dependent under this Plan may do so and he/she will be deemed to have completed his/her Late Entrant Waiting Period limitation period to the extent that it was satisfied under this Plan as a covered employee on the date of the transfer of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent. These special enrollment rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent that is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

(a) the current employee, or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;

(b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to the employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;

(c) the current employee, or dependent lost other coverage pursuant to one of the following events:

- the current employee, or dependent was under COBRA and the COBRA coverage was exhausted;
- the current employee, or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);

- the Plan is no longer offering benefits to a class of similarly situated individuals;
- the benefit package option is no longer being offered and no substitute is available; or
- the employer contributions were terminated; and

(d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than thirty-one (31) days after an event, as described in (c) above.

For an eligible current employee, or dependent who has met **each** of the conditions specified above, this Plan will be effective on the first of the month following receipt of a completed enrollment form.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee or retiree (and, if not otherwise enrolled, the current employee, spouse and/or other eligible dependent may be enrolled at the same time):

(a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and

(b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse, and/or other dependents of the current employee or retiree may also be enrolled as a dependent if the spouse and/or other eligible dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of thirty-one (31) days beginning on the date of marriage, birth, adoption or placement for adoption.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

(a) in the case of marriage, the first day of the month following receipt of a completed enrollment form;

(b) in the case of a dependent's birth, as of the date of birth; or

(c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

If the covered current employee has family coverage, newborns are automatically covered under this Plan from the moment of birth. An enrollment form or application will not be required.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the covered employee's active employment with the school district is terminated;
- (b) the last day of the month the covered employee ceases to be in a class of employees eligible for coverage;
- (c) the end of the period for which you have made contributions if you fail to make the next required contribution;
- (d) the date this Plan is terminated with respect to the school district, and there is no successor plan;
- (e) with respect to any single benefit, the date the maximum amount payable under the benefit has been paid to or on behalf of the covered employee;
- (f) the last day of the month the covered employee voluntarily elects to be terminated from this plan, subject to the pre-tax premium rules, see the section on **Pre-tax Premiums**.

If the covered employee ceases active employment due to layoff or authorized leave of absence, participation may be continued pursuant to rules adopted by the school district and applied on a uniform basis to all covered employees similarly situated. Also, participation may be continued if the covered employee is on an approved disability leave of absence pursuant to rules adopted by the school district and applied on a uniform basis to all covered employees similarly situated.

RETIREE ELIGIBILITY

Retired employees of the Southeast Polk Community School District and their covered dependents are eligible for dental coverage if each of the following conditions are met:

- the terms and conditions of eligible retirement as outlined in the Southeast Polk Community School District's applicable union agreements or employee resolutions as passed by the Southeast Polk Community School District board have been satisfied;
- the required years of service have been accumulated;
- the qualified employee was covered under this Plan on the day before retirement;
- any required contributions have been made.

RETIREE ENROLLMENT AND EFFECTIVE DATE

Retired employees and their covered dependents are eligible to continue coverage under this Plan provided each of the conditions listed in the previous section are met. Furthermore, on the date of retirement, coverage will continue as long as the retiree has elected to continue this coverage and there is no break in coverage.

RETIREE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month the covered retiree ceases to be in a class of retirees eligible for coverage;
- (b) the date this Plan is terminated with respect to an entire class of retirees to which such covered retiree belongs for coverage;
- (c) the end of the period for which the covered retiree has made contributions if the covered retiree fails to make the next required contribution;
- (d) the date this plan is terminated with respect to the school district, and there is no successor plan;
- (e) with respect to any single benefit, the date the maximum amount payable under the benefit has been paid to or on behalf of the covered retiree;
- (f) the last day of the month the covered retiree voluntarily elects to be terminated from the plan;
- (g) the date the covered retiree attains age 65. Dependents will be offered COBRA coverage.

If a covered retiree wishes to cancel coverage, the retiree must notify the school district prior to the desired date of cancellation.

Unless otherwise specified under this plan, when coverage terminates, benefits will not be provided for any dental services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

TYPES OF COVERAGE

There are different categories of coverage you may hold under this Dental Plan:

- With *single coverage*, the participant is the only one covered.
- With *family coverage*, the participant, his or her spouse, Common Law Spouse or Domestic Partner, and each of his or her eligible dependent children have coverage and are considered beneficiaries. Each covered family member beneficiary must be listed on the participant's dental application for coverage or added later as a new eligible beneficiary.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If you have a dependent child and we receive a Medical Child Support Order recognizing the child's right to enroll in this Dental Plan and /or any other benefit plan, we will promptly notify both you and the dependent child that the order has been received. We also will inform you and the dependent child of our procedures for determining whether the order is a Qualified Medical Child Support Order.

To be a Qualified Medical Child Support Order, the Medical Child Support Order must clearly specify the following:

- the participant's name and last known mailing address, if any;
- the name and mailing address of the dependent child specified in the court order;
- a reasonable description of the type of coverage to be provided to the dependent child or the manner in which the type of coverage will be determined;
- the period to which the order applies; and
- the name of each benefit plan to which the order applies.

Also, a Qualified Medical Child Support Order cannot require that a benefit plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet the requirements of Iowa Code Chapter 252E (1995) or Social Security Act Section 1908 with respect to group plans.

Within a reasonable time after receiving the order, we will decide whether the court order is a Qualified Medical Child Support Order and will notify you and the dependent child of that determination.

Once we decide that a court order is a Qualified Medical Child Support Order, the order is binding on both us and this Dental Plan, meaning that the dependent child is eligible to enroll under the applicable terms and conditions of this Dental Plan as well as our standard enrollment guidelines. We must allow enrollment of the dependent child regardless of any enrollment season restrictions that normally apply. Also, we must forward a copy of the order to Delta Dental and ask that they enroll the dependent child in this Dental Plan.

Within 60 days of our receipt of either the order or the application, whichever comes first, we will decide whether the dependent child is eligible for enrollment in this Dental Plan and will notify Delta Dental of the dependent child's eligibility status. If we offer more than one Dental Plan, we will enroll the dependent child in the same plan in which you are enrolled or a selected plan that is accessible to the dependent.

The dependent child's eligibility for and enrollment in this Dental Plan will be governed by all applicable terms and conditions, including, but not limited to, eligibility standards. If eligible, the dependent child will receive the same coverage that you do and will be allowed to enroll immediately regardless of normal enrollment procedures. We will withhold your share, if any, of the dependent child's contributions from your compensation and forward this amount to Delta Dental.

Within 30 days of receiving the order, we must tell both you and the dependent child that:

- the dependent child has been enrolled in a benefit plan; or
- the dependent child is ineligible for enrollment and why; or
- the order has been forwarded to Delta Dental without a determination of the dependent child's eligibility.

If the dependent child enrolls in this Dental Plan and /or any other benefit plan, we will provide all the following information to you and the dependent child:

- The name of the claims administrator(s) for the respective benefit plan(s).
- The dependent child's effective date(s) of coverage.
- The name of the benefit plan(a) and any other relevant identifying information (e.g. an account number.)

- The type of benefit plan(s) under which the dependent child has been enrolled, including whether dental, vision, office visits, and prescription drugs are covered services; and
- A brief description of the applicable deductibles, coinsurance, waiting periods for preexisting conditions, and other significant terms or conditions materially affecting the benefits or coverage.

The dependent child may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

If we decide that the order is *not* a Qualified Medical Child Support Order, each dependent child specified in the order is entitled to enroll in this Dental Plan and/or any other benefit plan may submit a written appeal to us. Within 30 days of receiving the appeal, we will respond in writing.

We may not revoke enrollment or eliminate coverage for a dependent child unless we have received satisfactory written evidence of any of the following conditions:

- The court or administrative order requiring coverage in a benefit plan is no longer in effect.
- The dependent's child's eligibility for or enrollment in a comparable dental plan that takes effect on or before the date the dependent's child's enrollment in this Dental Plan terminates.
- Our elimination of dependent child coverage for all employees.

We are not required to provide benefits under this Dental Plan or maintain coverage or for the dependent child if:

- You are no longer participating in this Dental Plan or paying premiums because we no longer owe you compensation; or
- You have terminated employment with us and have not elected to continue coverage.

WHEN BENEFITS BEGIN

Your rights to receive benefits under this Dental Plan begin on your effective date. If you have just started a new job, check with us or your group sponsor to find out your effective date.

Please note: Before you receive benefits under this Dental Plan, you have agreed on the application for benefits (or in documents kept by Delta Dental or us) to release any necessary information requested about you so Delta Dental can process claims for benefits. You must allow any dentist or his or her employee to give Delta Dental information about a treatment or condition. If Delta Dental does not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you fraudulently use the identification card or misrepresent or conceal material facts in your application, then Delta Dental may terminate your benefits.

WHEN BENEFITS END

Your eligibility for benefits under this Dental Plan will terminate at the end of the month for any of these reasons:

- You become ineligible for coverage under this Dental Plan. See *Eligibility* earlier in this section.
- You become unemployed. Termination of your coverage for this reason applies only if you receive your coverage through us.
- We will decide to discontinue coverage or replaces this coverage.
- Delta Dental decides to terminate this Dental Plan by giving written notice to us 90 days prior to termination.

Your coverage will end if any of the following occurs:

- You use your dental benefits fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, Delta Dental will recover any claim payments made.
- Delta Dental will not pay claims if we fail to make payment to Delta Dental when due.

Authority to Terminate, Amend, or Modify

We have the authority to *terminate, amend, or modify the benefits and coverage described in this Summary Plan Description at any time*. Any amendment or modification will be in writing. *If this Dental Plan is terminated, you may not receive benefits.*

Southeast Polk Community School District reserves the right to determine from time to time the level of contribution required from participants for the dental coverage, the right to take actions needed to operate the plan and the ability in selecting and changing the funding methods. If a funding method is desired, i.e. moving to Fully Insured, this has to be discussed with Delta Dental of Iowa as it will require all new documents and rates.

THE UNIFORMED SERVICES EMPLOYMENT AND EMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the eighteen (18) month period beginning on the date on which the person's absence begins prior to December 10, 2004 or the twenty-four (24) month period beginning on the date on which the person's absence begins on or after December 10, 2004; or
- the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
 - for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
 - for service of more than thirty (30) days but less than one hundred eighty one (181) days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;

- for service of more than one hundred eighty (180) days, no later than ninety (90) days after the completion of the period of service; or
- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than thirty-one (31) days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Military Health Systems, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the uniformed services.

“Uniformed Services” shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

In the event of a conflict between this provision and USERRA, the provision of USERRA, as interpreted by us or your former employer, will apply.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This Act requires an employer which employs fifty (50) or more employees to allow an employee who has been employed for twelve (12) months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of twelve (12) weeks of leave during any 12-month period, as defined by the employer, for: the birth of a child; placement of a child with the employee for adoption or foster care; care for a spouse, child or parent of the employee if the individual has a serious health condition; or a serious health condition which prevents the employee from performing the function of his/her regular position.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a “group dental plan” as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of employee.

Leave taken under the Act does not constitute a “qualifying event” so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of twelve (12) weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical leave Act of 1993. Please see your employer for more information.

CONTINUED COVERAGE

CONTINUED COVERAGE

There are some federal and state laws that may affect your dental benefits. These laws apply to continuing your coverage when you are no longer eligible for this Dental Plan.

Coverage Continuation Under Federal Law — COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to employers with 20 or more employees. COBRA entitles you and your eligible dependents to a continuation of coverage under this Dental Plan if coverage is lost due to any of the following qualifying events:

- Death of the employee covered under this Dental Plan.
- Termination of employment for reasons other than gross misconduct, or if your work hours are reduced to the point that you are no longer eligible for coverage.
- Divorce or legal separation.
- The employee covered under this becomes eligible for Medicare.
- Dependent children are no longer considered dependent by our eligibility rules.
- The employer from whom the covered employee retired files bankruptcy under federal law.

Please note: You or your eligible dependents are responsible for notifying us of a dissolution of marriage, legal separation or a child losing dependent status.

If you wish to continue your benefits, you must complete an election form and submit it to us within 60 days of the later of the date:

- you are no longer covered; or
- you are notified of the right to elect COBRA continuation coverage.

You will be responsible for paying any premiums to us for the continuation of benefits under this Dental Plan. Depending on how you qualify, you may continue your coverage for up to 18 or 36 months.

If during the period of COBRA coverage, a child is born to you or placed with you for adoption, the child can be covered under COBRA coverage and can have election rights of his or her own.

If you or any other family member who has elected COBRA coverage is determined to be disabled under the Social Security Act during the first 60 days of continuation coverage, your COBRA coverage may continue for up to 29 months. The 29-month period will apply to you and your spouse and/or eligible dependent child(ren) who elected COBRA coverage. You must provide notice of the disability determination to us within 60 days after the determination.

If you lose your coverage, contact us. We will help you with any necessary paperwork and let you know the cost of continuing your coverage.

Length of Coverage under COBRA

Continuation coverage ends at the earliest of one of these events:

- The last day of the 18-, 29-, or 36-month maximum coverage period, whichever is applicable.
- The first day (including grace periods, if applicable) on which timely payment is not made.
- The date on which we cease to maintain any group plan (including successor plans).
- The first day on which a beneficiary is actually covered by any other group plan. However, if the new group plan contains an exclusion or limitation relating to any pre-existing condition of the beneficiary, then coverage will end on the earlier of the satisfaction of the waiting period for pre-existing conditions contained in the new group plan or upon the occurrence of any one of the other events stated in this section.
- The date the qualified beneficiary is entitled to Medicare benefits.

COVERAGE CHANGES

EVENTS CHANGING COVERAGE

Certain events may require you to change who is covered by this Dental Plan. These events include:

Active Duty in the Military of a dependent child or spouse.

Addition or elimination of benefit package.

Appointment as a Legal Guardian of a child.

Birth or Adoption of a child.

Care of a Foster Child (when placed in your home by an approved agency).

COBRA.

Completion of Full-time Schooling of a dependent child.

Death.

Dependent satisfies or ceases to satisfy eligibility requirements.

Beneficiary who is a Dependent Child (who is *not* a full-time student or permanently disabled) reaches age 25 or is no longer an Iowa resident.

Divorce, Annulment, or Legal Separation of a participant.

Employment status.

Entitlement to Medicare or Medicaid.

Exhaustion of COBRA Coverage.

FMLA.

HIPAA special enrollment rights.

Judgement, decree, or order.

Legal marital status.

Marriage.

Marriage of a beneficiary who is a dependent child.

Number of Dependents.

Significant curtailment of coverage.

Spouse or Dependent Loses Eligibility for Qualifying Dental Coverage or we cease contributions to qualifying dental coverage. In this case, your spouse and any eligible, dependent children previously covered under the prior qualifying dental coverage are eligible for coverage under this Dental Plan.

NOTIFICATION OF CHANGE

You must notify Delta Dental within 31 days of the date of the event that changes the status your eligibility except birth or adoption of a child. Delta Dental of Iowa must be notified within 60 days of the date of the event that changes your eligibility for births or adoptions. You can ask your employer or group sponsor to help you make this request. If a change to your summary plan description is not made within 31 days of an event (except birth or adoption of a child which is 60 days), the person(s) affected may lose important coverage.

COVERAGE TERMINATION EFFECTS OF TERMINATION

If your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:

- *Delta Dental will not pay* for any services or supplies provided after the date the coverage is terminated.
- This Dental Plan *will retain legal rights*. This includes the right to initiate a civil action based on fraud, concealment, or misrepresentation.

If your coverage is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, Delta Dental will stop benefits the day your coverage is terminated.

DELTA DENTAL'S RIGHT TO RECOVER PAYMENTS PAYMENT IN ERROR

If for any reason Delta Dental makes payment under this Dental Plan in error, Delta Dental may recover the amount Delta Dental paid.

SUBROGATION

Once you receive benefits under this Dental Plan arising from an illness or injury, the Dental Plan will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage.

You and your family agree to all of the following:

- You will let Delta Dental know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that Delta Dental determines Delta Dental will need to enforce the Dental Plan's rights.;
- You will do nothing to prejudice the Dental Plan's rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting Delta Dental's written permission,
- You must reimburse Delta Dental to the extent of benefit payments made under this Dental Plan if payment is received from the other party or parties.
- You must notify Delta Dental if you or your beneficiaries have the potential right to receive payment from someone else.
- You must cooperate with Delta Dental to ensure that Delta Dental's rights to subrogation are protected.

OTHER INFORMATION NOTICE

You may send any notice to the Dental Plan at the following address:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919*

Any notice from Delta Dental to you is acceptable when sent to your address as it appears on Delta Dental's records or the address of the group through which you are enrolled.

You may contact our Claims Administrator at the following address:

*Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919*

NONASSIGNMENT

Benefits for covered services described in this Summary Plan Description are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. Any attempt to assign your rights under this Dental Plan or rights to payment without our consent will be void.

GOVERNING LAW

To the extent not superseded by the laws of the United States, this Summary Plan Description will be construed in accordance with and governed by the laws of the State of Iowa. Any action brought because of a claim under this will be litigated in the state or federal courts located in State of Iowa and in no other.

LEGAL ACTION

No legal or equitable action may be brought against Delta Dental because of a claim under this Dental Plan, or because of the alleged breach of the terms of this Dental Plan more than two years after the end of the calendar year in which the services or supplies were provided.

INFORMATION IF YOU ARE OR A MEMBER OF YOUR FAMILY IS ENROLLED IN MEDICAID

Assignment of Rights

This Dental Plan will provide payment of benefits for covered services to a participant, beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this Dental Plan, nor will it affect Delta Dental's determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and Delta Dental has a legal obligation to provide benefits for those services, then Delta Dental will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

ROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless participants have been notified, in writing, that another entity is the Plan Sponsor. This Plan, any business associate servicing this Plan, or the Claims Administrator cannot disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section. The Plan Sponsor of this Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

This Plan, any business associate servicing this Plan, or the Claims Administrator will disclose protected health information to the Plan Sponsor only to permit the Plan Sponsor to administer this Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by the Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and this Plan" sections that follow. Neither this Plan, nor the Claims Administrator, nor any business associate servicing this Plan will disclose protected health information to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants. Neither this Plan, nor the Claims Administrator, nor any business associate servicing this Plan will disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Sponsor:

(a) will not use or further disclose protected health information, except as permitted or required by law;

(b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;

(c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(d) will promptly report to this Plan, upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section (“Protected Health Information”); (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;

(f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;

(g) will track disclosures it may make of protected health information so that it can provide the information required by this Plan to account for disclosures in accordance with 45 CFR § 164.528;

(h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to this Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64;

(i) will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information; and

(j) will promptly report to your Plan any of the following incidents of which the sponsor becomes aware: (a) unauthorized access, use, disclosure, modification, or destruction of the Plan’s electronic protected health information, or (b) unauthorized interference with the system operations in the sponsor’s information systems that contain or provide access to the Plan’s electronic protected health information. When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, the Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form

or medium received from this Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, the Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THIS PLAN

Certain individuals under the control of the Plan Sponsor may be given access to protected health information received from this Plan, a business associate servicing this Plan, or the Claims Administrator. This class of employees will be identified by the Plan Sponsor to this Plan and the Claims Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to this Plan in the ordinary course of business. These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for this Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section (“Protected Health Information”). The Plan Sponsor will promptly report such violation or noncompliance to this Plan, and will cooperate with this Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance. The sponsor will ensure that these provisions for adequate separation between the sponsor and the Plan are supported by reasonable and appropriate security measures.

RE-TAX PREMIUM PROGRAM

The pre-tax premium program allows you to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that you would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that you pay no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions you make. Furthermore, your premium is also exempt from state income taxes in most states. This means a higher take-home pay for you, than if you purchased this Plan with after-tax dollars.

Note: Because the premium contributions you make to this Plan are not taxed as wages for Social Security purposes, your ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including your earnings history, whether you are above or below the Social Security “wage base,” and what happens to the Social Security laws between now and when you retire. The pre-tax premium program is available to you if you meet the eligibility requirements under this Plan. Your premium will automatically be deducted from your paycheck on a pre-tax basis. If you desire your premiums be paid on an after-tax basis, you must notify Human Resources. Your enrollment regarding the tax status of your premiums will continue in effect until you change it. You can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if you experience a family status change, as defined by the Internal Revenue Service.

Your choices are in effect for the entire Plan Year. Only under special circumstances, such as changes in family status (including, but not limited to): marriage, divorce, legal separation) death of a spouse/domestic partner or child, birth or adoption of a child, the termination or commencement of your spouse’s/domestic partner’s employment, a significant increase in your costs with respect to this Plan, the switching from part-time to full-time employment status, or the reverse, by you or your spouse/domestic partner or the taking of an unpaid leave of absence by you or your spouse/domestic partner - may you apply to change your selected benefits. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

**Delta Dental of Iowa
P.O. Box 919
Ankeny, IA 50021-0919**

**Hearing Impaired Toll Free: 1-888-287-7312
Toll Free: 1-800-544-0718
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Enrollment@deltadentalia.com**