

the

Connection



Specially Prepared for the Employees of

**NWSEBP&T – South Shore**

**Administrators, Teachers, Central Office**

**Important Information About Your Dental Benefit Plan**

Delta Dental Plan of Wisconsin is proud to be selected as your dental claims administrator. Delta brings the added value of our DeltaPremier Dentist Network to your dental benefits and is the only company that specializes exclusively in dental claims administration.

**Your Benefit Design**

Your Dental Benefit Plan provides a comprehensive program to ensure your dental health. Coverage is included for important preventive care, and also for treatment needed as a result of dental disease or accidental injury. Your dental benefit handbook provides a thorough explanation of your dental plan, including any limitations or exclusions that might apply.

**A Brief Summary of Benefits**

	<u>Benefit</u>
<b>Individual Annual Deductible</b>	\$ .00
<b>Family Annual Deductible</b>	\$ .00
<b>Individual Annual Maximum</b>	\$1,000.00
<b>Individual Lifetime Orthodontic Maximum</b>	\$1,500.00
<b>Dependent children are covered to the end of the year they reach age 25.</b>	
<b>Diagnostic &amp; Preventive Services</b>	100%
<i>Examinations, teeth cleaning (prophylaxis), fluoride treatments, space maintainers, bitewing &amp; full mouth x-rays</i>	
<b>Basic Restorative Services</b>	100%
<i>Emergency treatment to relieve pain, fillings, root canal &amp; gum disease treatment, extractions and oral surgery</i>	
<b>Major Restorative Services</b>	100%
<i>Crowns, inlays &amp; onlays</i>	
<b>Major Restorative Services</b>	100%
<i>Available to Plan Members who have been covered under this Plan for a minimum of 12 consecutive months.</i>	
<i>Complete &amp; partial dentures, fixed bridges</i>	
<i>Repairs &amp; adjustments</i>	
<b>Orthodontics</b>	50%
<i>Coverage for orthodontics is included for dependent children to age 25</i>	
<i>Coverage for orthodontics is also included for the employee and spouse</i>	



## Solid Benefits from the Dental Benefit Specialists

Delta Dental is the largest and oldest dental benefits specialist in the country. It was built on the guiding principle that dental benefits should be easy to use and hassle-free. Delta Dental Plan of Wisconsin was founded more than 35 years ago with the same goal and now serves more than one million people with a full range of dental benefits programs.

As a Delta Dental subscriber, you may see any dentist you like. However, the key to *The Delta Difference*<sup>SM</sup> is our unique relationship with contracted dentists. When you select a DeltaPremier dentist, you are guaranteed the fullest benefits of your program. The most accurate and up-to-date information on our DeltaPremier Dentists is available on our website at [www.deltadentalwi.com](http://www.deltadentalwi.com), or by calling Delta toll free at 800.236.3712.

<b>Advantages of DeltaPremier Network Dentists</b>	<b>DeltaPremier Network Dentists</b>	<b>Noncontracted dentists</b>
<b>Agreed-to fee ceilings (no balance-billing)</b> <i>Dentist agrees to fee ceilings. If his/her normal charge is higher than the fee ceiling, he/she can't pass the balance on to you.</i>	✓	
<b>Convenient claims processing</b> <i>Dentist is required to file claims on your behalf, saving you the hassle of doing so yourself. Claims payments go directly to the dentist.</i>	✓	
<b>Treatment guarantees</b> <i>Examples: Repair or replace dental restorations or dental sealants should they fail within 24 months.</i>	✓	

### After July 1, 2003...

Send all claims, regardless of date of service to: Delta Dental Plan of Wisconsin, Inc.  
P.O. Box 828  
Stevens Point, WI 54481

### Delta's Website

Delta's website has a lot to offer. You can use it to obtain information about coverage under your plan, check the status of your claims, find a network dentist, and learn ways to improve and protect your oral health. We're at [www.deltadentalwi.com](http://www.deltadentalwi.com).

For eligibility, claims or dentist information, visit our website at: [www.deltadentalwi.com](http://www.deltadentalwi.com)

Also, our Benefit Advisors are available every weekday from 7:30 a.m. to 5:00 p.m. (CST) to answer any questions you may have. Call us at 800.236.3712. We look forward to talking with you!



# **Summary Plan Description**

for

**NORTHERN WISCONSIN SCHOOLS EMPLOYEE BENEFIT  
PLAN AND TRUST**

**SCHOOL DISTRICT OF SOUTH SHORE, WI  
ADMINISTRATORS, TEACHERS, AND CENTRAL OFFICE**

**97709**

 **DELTA DENTAL®**

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**ACCEPTANCE**

THE NORTHERN WISCONSIN SCHOOLS EMPLOYEE BENEFIT PLAN AND TRUST  
(Hereinafter called the Company)

PLAN DOCUMENT FOR SELF-FUNDED  
GROUP DENTAL BENEFITS FOR  
SCHOOL DISTRICT OF SOUTH SHORE, WISCONSIN  
Teachers, Administrators & Central Office Clerical Staff

Effective July 1, 2003, the Employer adopts the Dental Protection Plan for School District of South Shore, Wisconsin to provide self-funded benefits for its Employees and their Dependents.

This Plan replaces the Employer's previous self-funded plan of Dental Benefits. It is the intent of the Employer to provide continuous eligibility and coverage from the previous plan to this Plan. This Plan is subject to all the terms, provisions and conditions contained within this Plan Document.

The Plan is an agreement between the Employer and its Employees. Since it is the Employer's Plan, the responsibility for accurate and complete maintenance of the Plan Document is the Employer's. Delta Dental Plan of Wisconsin, Inc. a third party administrator, will help develop and maintain this Plan Document, but the ultimate responsibility for the Document is the Employer's.

The Employer hereby acknowledges acceptance of this Master Plan Document.

-----  
Date

-----  
Signature

-----  
Print or Type Name and Title

-----  
Witness Signature

-----  
Print or Type Witness Name

## SCHEDULE OF COVERAGE

**NOTE:** This is only a summary, specific services and supplies may be subject to other Maximum benefit payments, and/or Exclusions and Limitations as outlined in the Plan Document.

**DEDUCTIBLE AMOUNT PER CALENDAR YEAR PER PLAN MEMBER** NONE

### PAYMENT PERCENTAGES

DIAGNOSTIC & PREVENTIVE SERVICES	100%
ANCILLARY SERVICES	100%
ENDODONTICS	100%
RESTORATIONS	100%
ORAL SURGERY & SIMPLE EXTRACTIONS	100%
PERIODONTICS	100%
PROSTHODONTICS	100%
ORTHODONTIC SERVICES	50%

### MAXIMUM PAYMENT AMOUNTS

ORTHODONTIC SERVICES - LIFETIME	\$1,500
ALL OTHER COVERED SERVICES - CALENDAR YEAR	\$1,000

## DEFINITIONS OF GENERAL TERMS

When used and capitalized in this document, these terms have the following definitions:

**CALENDAR YEAR** means the period from January 1 through the following December 31.

**CO-PAYMENT PERCENTAGE** means any percentage of a bill that is the Plan Member's responsibility to pay after the Plan has paid.

**COSMETIC PROCEDURE** means a procedure performed solely for the improvement of a Plan Member's appearance rather than for the improvement or restoration of bodily function.

**COURSE OF DENTAL TREATMENT** means a planned program for the treatment of a dental condition which:

1. May be done by one or more Dentists;
2. Is diagnosed by the attending Dentist by an oral examination; and
3. Begins on the date a Dentist first treats the condition.

**COVERED EXPENSES** are charges for services that are covered under the Plan. Charges, although eligible, are subject to the Co-payment Percentage provision and, therefore, are the Plan Member's responsibility to pay. Charges for non-covered expenses are also the Plan Member's responsibility.

**DELTA** means Delta Dental Plan of Wisconsin, Inc.

**DENTAL HYGIENIST** means a duly licensed Dental Hygienist who works under the supervision of a Dentist.

**DENTALLY NECESSARY** means dental care services, supplies or treatment, which are required to treat the Plan Member's condition or Injury. The Plan will determine whether a service or supply is Dentally Necessary based on the review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of the Plan Member's symptoms, disease, defect or Injury.
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures.
3. The most appropriate and cost-effective level of service or supply which can safely be provided to the Plan Member.
4. Not primarily for the convenience of the Plan Member's family or the Dentist.
5. Appropriate with regard to standards of generally accepted dental practice.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service, or supply does **NOT** in itself make it eligible for payment.

**DENTIST** means a duly licensed Dentist or Physician who is acting within the scope of his/her license.

- Delta Dental PPO Dentists  
**Delta Dental PPO Dentists have signed a contract with Delta Dental, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these dentists agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.**
- Delta Dental Premier Dentists  
As a participant of this dental plan, you are free to see any dentist you choose on a treatment by treatment basis. If your dentist has signed a contract with Delta Dental, he or she has agreed to accept payment directly from Delta based on the Maximum Plan Allowance (MPA). The Delta Dental Premier Dentist will charge you only for copayments, deductibles and procedures not covered by this dental plan. After a claim for dental procedures is filed, you will receive an Explanation of Benefits form indicating the amount Delta paid to the Delta Dental Premier Dentist and the amount, if any, you owe the

dentist.

- **Noncontracting Dentists**

If your dentist has not signed a contract with Delta Dental, claim payments will still be calculated on the MPA.

Please note that if the fee charged by a Noncontracting dentist is not allowed in full, Delta Dental is not implying that the dentist is overcharging. Dental fees vary and are based on each dentist's overhead, skill and experience. Therefore, not every dentist will have fees that fall within Delta's MPA.

For information on Delta Dental dentists, call 800.236.3712, or visit Delta's web site at [www.deltadentalwi.com](http://www.deltadentalwi.com)

**DEPENDENT** includes only an Employee's:

1. Lawful spouse; and
2. Unmarried biological child; adopted child, including a child placed for adoption; a stepchild; or a foster child, provided all such children are primarily dependent upon the Employee for support. Such children shall be eligible for coverage until the earliest of the following:
  - a) To the end of the month in which the child marries;
  - b) To the end of the Calendar Year in which the child becomes 25 years of age.

**NOTE:** If a child, who is not a Full-time Student, earns more than an amount equal to 50% of the Federal minimum wage for a 40-hour week in any given monthly period, such child shall not be considered primarily dependent upon the Employee for financial support.

**NOTE:** Specific dental services have a separate age limitation.

3. A child who is otherwise ineligible, but:
  - i) for whom coverage is required by a Qualified Medical Child Support Order (QMCSO) or by an administrative process established under state law; or
  - ii) who reaches the age limit while covered by this Plan and is

incapacitated and for whom this Plan has received proof of incapacity within 31 days and annually thereafter.

An incapacitated child is one:

1. Who is dependent on the Employee for support and maintenance;
2. Who has developmental disability or physical handicap; and
3. Is diagnosed by a Physician as having a permanent or long term continuing disabling condition.

"Developmental disability" means substantial handicap which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder.

Placement for adoption occurs when a plan participant or beneficiary, in anticipation of adopting a child assumes and retains legal obligation for the total or partial support of that child. Adoptive placement ceases when or if legal obligation ceases.

No person may be covered under this Plan as both an Employee and as a Dependent of an Employee, or as a Dependent of more than one Employee. The term Dependent does not include any person serving in the armed forces of any country.

**EFFECTIVE DATE** means the date on which a person's coverage under this Plan begins.

**EMPLOYEE** means a regular full-time or part-time Employee of the Employer, who is regularly scheduled to perform the principle duties of his/her occupation the required number of hours as specified by the Employer and who is enrolled and eligible for coverage under the Plan. The Plan may cover retired Employees. Full-time seasonal employees, full-time temporary employees and substitute employees are not eligible for coverage under the Plan. Contact the Human Resource Department for additional information.

**EMPLOYER** means School District of South Shore, Wisconsin.

**EXPERIMENTAL/INVESTIGATIONAL/INVESTIGATIVE** means a drug, device, medical treatment or procedure that meets any of the following:

1. The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

For purposes of this definition, Reliable Evidence means published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**FULL-TIME STUDENT** means an unmarried child within the age specified in the Definition of a Dependent who is enrolled at an accredited school. The school will determine the meaning of full-time. Coverage will continue during semester breaks, provided the Dependent is enrolled for the following semester/year.

**IMMEDIATE FAMILY** means the Plan Member's spouse, children, brothers, sisters, grandparents, or the parents of the Plan Member or his/her spouse.

**INCURRED** means the day and time of day Covered Expenses are provided. It does

not include a date on which a Plan Member contracts for future delivery of supplies or services.

**LIFETIME** wherever used in the Plan in reference to benefit maximums and limitations, means while covered under the Plan. Under no circumstances does "**Lifetime**" mean during the lifetime of the Plan Member.

**MASTER PLAN DOCUMENT** means the Plan Document detailing the provisions of the Plan.

**MAXIMUM PLAN ALLOWANCE** is established by Delta and developed from various sources, such as contracts with dentists, input from our dental consultants, the simplicity or complexity of the procedure, and a compilation of the billed charges for the same procedures by dentists in various geographic areas of the state.

**MEDICAID** means the medical benefits provided by Title XIX of the Social Security Act, as amended.

**MEDICARE** means the medical benefits provided by Title XVIII of the Social Security Act, as amended.

**PAYMENT PERCENTAGE** means the amount payable by the Plan for Covered Expenses. The Payment Percentage is shown in the Schedule of Coverage.

**PHYSICIAN** means a legally licensed Doctor of medicine and Surgery or Doctor of dental Surgery. A Physician shall not include the Plan Member or any member of his/her Immediate Family.

**PLAN** means the Plan of benefits offered by the Employer according to the provisions of the Master Plan Document.

**PLAN MEMBER** means an Employee or Dependent, as defined in the Master Plan Document, who is covered by the Plan.

**QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)** means a state court medical child support order which specifies:

1. The name and last known mailing address of the plan participant and each alternate recipient covered by the order;
2. A reasonable description of the type of coverage or benefit to be provided to the alternate recipient;
3. The period to which the medical child support order applies; and
4. Each plan to which the order applies.

**SCHEDULE OF COVERAGE** means the Schedule at the beginning of the Master Plan Document, or as later amended, which specifies the level of benefits provided by the Plan.

**TREATMENT PLAN** means a written report prepared by a Dentist, which shows the proposed treatment for the Plan Member's dental disease, defect, or Injury. A Treatment Plan shows all necessary procedures, the series of visits, and the charges for the treatment.

## **ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE**

### **EMPLOYEE ELIGIBILITY DATE**

For new Employees, coverage becomes available on the first day of employment.

**NOTE:** If an Employee does not enroll for coverage under this Plan when he/she is initially eligible to enroll for coverage, he/she may enroll for coverage under this Plan at a later date subject to the Special Enrollment Period, as explained elsewhere in the Plan Document.

### **EMPLOYEE EFFECTIVE DATE OF COVERAGE**

Coverage becomes effective on the date the eligibility requirement is satisfied, provided the Employee has enrolled for coverage.

### **DEPENDENT ELIGIBILITY DATE**

An Employee becomes eligible for Dependent coverage on the later of:

1. The date the Employee becomes covered;
2. The date the Employee first acquires an eligible Dependent; or
3. The date the Employee is required, by a Qualified Medical Child Support Order, to provide Dependent coverage.

### **DEPENDENT EFFECTIVE DATE OF COVERAGE**

Dependent coverage required by a Qualified Medical Child Support Order (QMCSO) or by an administrative process established under state law will become effective on the latest of the following dates:

1. The date the Employee becomes eligible for Dependent coverage;
2. The date specified by the QMCSO;
3. The date the Employee's coverage becomes effective;

4. The date the person becomes a Dependent.

All other Dependent coverage will become effective on the same day as the Employee upon whom they are dependent, provided the Employee has enrolled for family coverage.

Individuals who become an eligible Dependent of an Employee after the Employee's Effective Date of coverage will be eligible for coverage as explained under the CHANGE IN STATUS provision.

**NOTE:** If an Employee does not enroll his/her eligible Dependents for coverage under this Plan when they are initially eligible to be enrolled for coverage, the Employee may enroll his/her eligible Dependents for coverage under this Plan at a later date subject to the Special Enrollment Period, as explained elsewhere in the Plan Document.

### **CHANGE IN STATUS**

If an Employee is covered for single coverage and wants a change to family coverage because of a change in marital status, he/she must request family coverage within 31 days of the date of marriage, in order for coverage to become effective on the date of the marriage.

Should an Employee's marital status change due to divorce or legal separation, notification of that change must be given to the Employer within 60 days of the date of that change.

Employees who have single coverage may request a change to family coverage to add an eligible Dependent child, by submitting a new enrollment card within 31 days of acquiring the child as an eligible Dependent, in which case the child's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Employees who have family coverage, may add an additional eligible Dependent, by submitting a new enrollment card within 31 days of acquiring the individual as an eligible Dependent, in which case the individual's coverage would become effective on the date he/she became an eligible Dependent of the Employee.

Any request for coverage after the 31 days will be subject to the Special Enrollment Period provision.

## **SPECIAL ENROLLMENT PERIOD**

If an Employee declines coverage for himself/herself or for his/her Dependents (including the Employee's spouse) because of other health coverage, the Employee will be able to enroll himself/herself and/or his/her Dependents in this Plan at a future date, provided that the Employee requests coverage within 30 days after other coverage ends.

This special enrollment period **ONLY** applies to individuals:

Whose prior Creditable Coverage:

1. Was under COBRA and they exhausted that COBRA coverage; or
2. Was not under COBRA and they lost that prior Creditable Coverage either due to events that are similar to COBRA qualifying events (including, but not limited to loss of eligibility as a result of legal separation, divorce, death, and termination or reduction in hours of employment) or due to the cessation of the employer contributions for that prior Creditable Coverage.

An Employee must make a request for Special Enrollment within 30 days of the loss of the previous Creditable Coverage and must supply the Plan with a Certificate of Period of Creditable Coverage under the other group health plan.

In addition, if an Employee declines coverage in this Plan for himself/herself or for his/her Dependents, the Employee will be allowed to enroll for coverage for himself/herself and/or his/her Dependents at a future date if the Employee has acquired a new Dependent as a result of marriage, birth, adoption, or placement for adoption, provided that the Employee requests coverage within 30 days after the marriage, birth, adoption or placement for adoption.

### **EXAMPLES:**

1. In the case of marriage, an Employee who had previously declined coverage could become covered, with or without his/her spouse, under the Special Enrollment Period provision.
2. In the case of birth or adoption, an Employee and/or his/her spouse, who had previously declined coverage in this Plan could become covered under the Special Enrollment Period provision.

## TERMINATION OF INDIVIDUAL COVERAGE

Coverage under this Plan shall terminate according to the rules established by the Employer. Contact the Human Resource Department for additional information.

**NOTE:** Coverage shall be canceled automatically, without notice, if a Plan Member:

1. Attempts, through deceit, to obtain benefits that otherwise would not be provided by this Plan; or
2. Attempts to obtain benefits for someone not entitled to benefits under this Plan.

This Plan shall at all times be in compliance with the Family and Medical Leave Act (FMLA) of 1993, or as later amended, provided the Employer is required to comply with the FMLA.

## UNIFORMED SERVICES CONTINUATION AND REINSTATEMENT PROVISION

### Continuation

A Plan Member who:

1. Is employed by the Employer;
2. Is determined by the Employer to be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA);
3. Is absent from his/her position of employment with the Employer by reason of service in the uniformed services; and

4. Would otherwise have his/her coverage under the Plan terminated, may elect to continue the coverage under the Plan that the Plan Member and his/her eligible covered Dependents had prior to such absence for a period not to exceed the lesser of:
  1. The eighteen month period beginning on the date on which the Plan Member's absence begins; or
  2. The day after the date on which the Plan Member fails to apply for or return to a position of employment as specified by the Employer.

### **Reinstatement**

Upon re-employment, coverage under the Plan will be reinstated for a person who was absent from his/her position of employment with the Employer by reason of service in the uniformed services, as well as for his/her eligible Dependents who were covered Plan Members under the Plan at the time the absence began provided that:

1. The person was a covered Plan Member under the Plan until the time his/her absence from employment with the Employer commenced by reason of service in the uniformed services;
2. The person makes application for re-employment within the time limit specified by the Employer; and
3. At the time the person makes application for re-employment, he/she is entitled to benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

In such instances, an exclusion of the Plan, Pre-existing Condition Limitation, or waiting period will not be applied, if that exclusion of the Plan, Pre-existing Condition Limitation, or waiting period would not have been applied had coverage not been terminated as a result of service in the uniformed services. This also applies to any eligible Dependent of the covered person who becomes covered by the Plan as a result of such reinstatement of coverage.

An exclusion or waiting period may be imposed for any Injury or Sickness determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

## GENERAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for the following, **UNLESS** specifically stated otherwise in this Plan:

1. Expenses due to a work related Injury or Sickness sustained while doing anything pertaining to any occupation or employment for remuneration or profit for which all or part of the expense is payable by Workers' Compensation or similar law.
2. Expenses Incurred by a Plan Member that may be covered or reimbursed by any public program, or by any national, state, provincial, county, local government or any other political subdivision, instrumentality or agency thereof, except Medicare and Medicaid.
3. Charges for military service related Injury, Sickness (past or present), Mental/Nervous Disorder(s) or Substance Abuse condition furnished by a Hospital or facility operated by any foreign government agency, or the United States Government or any authorized agency of the United States Government or furnished at the expense of such government or agency, to the extent the Plan is legally allowed to exclude these charges.
4. Services or supplies Incurred due to an Injury or Sickness caused by war or an act of war (whether declared or undeclared), nuclear explosion or nuclear accident or major nuclear disaster, or service in the armed forces of any country.
5. For expenses made which are in excess of the Maximum Plan Allowance (MPA).
6. For any service or supply:
  - a. Which is not recommended or approved by a Physician or Dentist;
  - b. Rendered by an individual other than a Physician or Dentist as defined by this Plan; or
  - c. Rendered outside the scope of the provider's license.
7. Expenses for completion of claim forms or for preparation of dental reports; for missed appointments or for telephone consultations.

8. For services and supplies provided through a medical department, clinic or other facility provided by or maintained by the Plan Member's employer, or a medical clinic or similar facility for which services or supplies are or should be available without charge to the Plan Member.
9. Expenses of any kind, which are not in connection with, or are not Dentally Necessary.
10. Charges for services and supplies which are Experimental/ Investigational/Investigative.
11. Services performed by a person who is a member of the Plan Member's Immediate Family or who resides in the Plan Member's home.
12. Charges in excess of any maximum benefit stated in the Plan.
13. Expenses for which the Plan Member has no legal obligation to pay or for an expense which would not have been made if the person did not have coverage under this Plan.
14. Charges for treatment, services and supplies in connection with any Injury caused by the Plan Member's: engaging in an illegal occupation; commission of, or an attempt to commit, a felony; or voluntary participation in a riot, insurrection or civil disobedience.
15. Charges Incurred outside the United States if the Plan Member traveled to such location for the sole purpose of obtaining dental services or supplies.
16. State tax on goods or services.
17. Services, supplies, or equipment, which are not specifically, described as dental services.
18. Services, supplies, or equipment furnished:
  - a. Before the Plan Member's Effective Date; or
  - b. After the date the Plan Member's coverage ends, except for:
    - i) prosthetic devices which were ordered and fitted before, and completed within 60 days after, the date the Plan Member's coverage ends; and

- ii) procedures, other than prosthetics, which were begun before, and completed in one visit within 31 days after, the date the Plan Member's coverage ends.
- 19. Charges for anything the Plan Member and his/her Dentist choose other than covered standard dental treatment, appliances or procedures.
- 20. Dental services for congenital malformations, or primarily for cosmetic or esthetic purposes, unless required due to an Injury. This exclusion applies to existing teeth, not to congenitally missing teeth.
- 21. Charges for:
  - a. Any duplicate appliance or device;
  - b. The replacement of a lost, stolen, or missing prosthetic device; or
  - c. The replacement or repair of an orthodontic appliance.
- 22. Charges for:
  - a. Oral hygiene counseling and dietary instruction;
  - b. Plaque control programs;
  - c. Implantology;
  - d. Sealants;
  - e. Splinting procedures;
  - f. Desensitizing treatment;
  - g. Diagnostic casts, if charged for separately.
- 23. Charges for dental services for which benefits are otherwise provided under the Plan Member's surgical/medical or prescription drug coverage.
- 24. Precision attachments, precision partials, or treatment partials **EXCEPT** as specified otherwise in the Plan.

25. Charges for veneers or similar properties of crowns and pontics placed on or replacing teeth other than the 10 upper and lower most anterior (front) teeth.
26. Appliances, restorations, or procedures needed to adjust vertical dimension or to restore occlusion, except as an integral part of comprehensive orthodontic treatment.
27. Charges for pulp vitality tests.
28. Damage caused by the negligence of any third party.

## **DENTAL PLAN**

### **PRE-DETERMINATION OF BENEFIT**

Before receiving dental services for a Course of Dental Treatment of more than \$100.00, the Plan Member or his/her Dentist may request a pre-determination of benefits by sending the Treatment Plan to Delta. Delta will estimate what benefits are payable. Where the Plan gives prior written estimate for a treatment, service or supply, benefits will be paid if the Plan Member's coverage is in force at the time such treatment, service or supply is provided and if the treatment plan has not changed.

### **COVERED DENTAL EXPENSES**

The Plan will pay benefits for Covered Expenses Incurred by a Plan Member for dental services, only when performed by a Dentist, a Doctor of Medical Dentistry (D.M.D.) or a licensed or certified Dental Hygienist, or other dental provider working under the direction and supervision of the Dentist or doctor of medical dentistry. The payment is subject to the General Limitations and Exclusions and all other provisions of the Plan. The Payment Percentages and Maximums are shown in the Schedule of Coverage.

### **DIAGNOSTIC AND PREVENTIVE SERVICES**

1. Dental radiographs (x-rays). This includes full mouth, supplementary bitewing, and other dental radiographs required to diagnose a specific condition requiring treatment.

Diagnostic services include panoramic radiographs.

**LIMITATIONS:**

- i) 1 full mouth x-ray series in a period of 24 consecutive months;
  - ii) 1 supplementary bitewing x-ray series, limited to 2 in a Calendar Year; or
  - iii) panoramic x-rays or a full mouth series of x-rays, but **NOT** both.
2. Routine oral examinations and prophylaxis (scaling and cleaning of teeth).

**LIMITATION:**

Oral exams and prophylaxes are limited to 2 per Calendar Year.

3. Topical fluoride treatments - **LIMITED** to Plan Members under 19 years of age.
4. Space maintainers that replace prematurely lost teeth - **LIMITED** to Plan Members under 19 years of age.
5. Occlusal adjustments up to a \$100.00 Lifetime maximum.

**ANCILLARY SERVICES**

1. General anesthesia only when required for oral dental surgical procedures covered under this benefit. (Charges for local anesthesia and/or analgesia will be included in the cost of the restoration(s) or procedure(s) for which treatment was needed.)
2. Injections of antibiotic drugs by the attending Dentist.
3. Emergency palliative care. Palliative care is care which relieves the symptoms of disease flare-up, but which does not result in an improvement of the Plan Member's stationary condition.
4. Emergency denture repairs and adjustments. (See "Prosthodontics" or non-emergency repair provisions).

## ENDODONTICS

Root canal treatment.

## RESTORATIONS

1. Direct filling procedures - including amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations of diseased or broken teeth, including stainless steel crowns.
2. Indirect filling procedures: inlays, onlays, or crowns to restore diseased or broken teeth, only if the teeth cannot be restored by direct filling procedures because of severe decay or fracture. If the Plan Member and his/her Dentist choose an indirect restoration when it is not Dentally Necessary, the Plan will pay an amount based on the cost of a direct restoration. The Plan Member will be responsible for the balance of the payment. Indirect restorations are also called cast restorations.

Parts of indirect restorations, such as gold dowel pins, are covered at the same Payment Percentage as the full indirect restoration.

## ORAL SURGERY & SIMPLE EXTRACTIONS

Excluding those services covered under the Plan Member's surgical-medical plan.

## PERIODONTICS

Treatment of the gums and supportive tissues of the teeth.

## PROSTHODONTICS

**The following benefits are available only to Plan Members who have been covered by the Plan for a minimum of twelve consecutive months.**

1. Appliances – fixed bridges, partial or full removable dentures. The charge for the initial installation will be considered to include any adjustments needed during the following six months. Separate charges for adjustments during the first six months will be considered Covered Expenses up to the

point where the total of the installation and the adjustments equal the Maximum Plan Allowance (MPA) for that appliance.

a. Inlays and crowns used as abutments for the appliance. Double abutments are covered only if Dentally Necessary.

b. For partial dentures:

If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, but the Plan Member or his/her Dentist select a more elaborate or precision appliance, the Plan will pay the benefits that the Plan would pay for the cast chrome or acrylic partial denture. The balance of the cost is the Plan Member's responsibility.

c. For complete dentures:

If the Plan Member and his/her Dentist decide on personalized restorations or specialized techniques instead of standard procedures, the Plan will pay the benefits that the Plan would pay for the standard denture services. The balance of the cost is the Plan Member's responsibility.

## 2. Repairs and Adjustments

a. Relining or rebasing of denture more than six months after the installation of an initial or replacement denture, but not more than once in any period of 36 consecutive months.

b. Repairs and adjustments to an existing bridge or denture occurring after six months from installation, if it can be fixed so that it is usable.

c. Addition of teeth to an existing bridge or denture if teeth are pulled after the appliance was first made.

3. Replacement of an existing removable partial or full denture, or fixed bridge by a new removable partial or full denture, or fixed bridge; or the addition of teeth to an existing removable partial denture or to a bridge. The Plan Member or his/her Dentist must provide satisfactory evidence that:

- a. The replacement of teeth or addition of teeth is required to replace one or more teeth extracted after the existing removable partial or bridge was inserted; or,
- b. The existing denture or bridge was inserted at least 5 years before its replacement and the existing denture or bridge cannot be made serviceable; or,
- c. The existing denture is an immediate temporary full denture, which cannot be made permanent. Replacement by a permanent denture must take place within 3 months from the date of the initial insertion of the immediate temporary full denture.

The Plan covers the replacement of an existing denture only if the existing denture is unserviceable and cannot be made serviceable. The Plan pays the benefit level, which applies to the cost of services necessary to make the appliances serviceable. The Plan will cover replacement of prosthodontic appliances only if at least 5 years have elapsed since the date of the initial insertion of that appliance.

4. Double abutments are covered only when Dentally Necessary.
5. Treatment partials are covered only when used as a space maintainer for Plan Members under 19 years of age.

## **ORTHODONTIC SERVICES**

1. Orthodontic diagnostic procedures and treatment consisting of surgical therapy (including orthodontic extractions), banding and appliance therapy.
2. Method of payment - The Plan pays benefits for orthodontic services based on the approved Treatment Plan as follows:

One-fourth of the total case fee is considered the initial or down payment fee. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percentage stated on the Schedule of Coverage page.

**NOTE:** The Plan does not pay for orthodontic benefits if the Plan Member's coverage terminates, or if the Plan Member attains the age limit for orthodontic services during a Course of Dental Treatment.

If orthodontic treatment is terminated for any reason before completion, the Plan's obligation to pay benefits ends with the payment to the date of termination. If services are resumed, benefits for the services, to the extent remaining, resume.

### **CARE PROVIDED BY THE UNITED STATES GOVERNMENT**

The Plan will reimburse for care rendered by the Veterans Administration for non-service connected disabilities, on the same basis as these services are otherwise covered by the Plan.

The Plan will reimburse for care rendered by the United States to military retirees and dependents who are covered by this Plan on an Inpatient basis through a facility of the uniformed services, on the same basis as these services are otherwise covered under the Plan.

### **COORDINATION OF BENEFITS**

The Plan contains a non-profit provision coordinating it with other plans under which an individual is covered so that total benefits available will not exceed 100% of the allowable expense.

An "Allowable Expense" is any necessary, reasonable and customary expense at least a portion of which is covered by one of the plans covering the Plan Member for whom a claim is made. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be considered both an allowable expense and a benefit paid.

"Plan" means any plan providing health benefits or health services including but not limited to:

1. Group, blanket or franchise insurance coverage;
2. Group practices and other group pre-payment coverage;
3. Any coverage under labor-management trustee plans, union welfare

plans, employer organization plans, or employee Benefit organization plans; and

4. Any coverage under governmental programs such as Medicare and any coverage required or provided by any statute, such as no-fault auto insurance. This Plan will be secondary to the above listed plans to the extent of the law. The Plan will be primary to Medicaid and will coordinate benefits with Medicare according to the law in effect at the time the claim is Incurred.

### **EFFECT ON BENEFITS**

When a claim is made, the primary plan pays its benefits without regard to any other plan. The secondary plans adjust their benefits so that the total benefits available will not exceed the allowable expenses. No plan pays more than it would without the coordinating provision.

A plan without a coordination provision is always the primary plan. If all plans have such a provision:

1. The plan covering the individual directly, rather than as an Employee's Dependent, is primary and others are secondary;
2. If a child is covered under both parent's plans, the plan covering the parent whose birth date, excluding the year of birth, occurs earlier in the Calendar Year shall be the primary plan, and the plan covering the parent whose birth date is later in the Calendar Year shall be the secondary plan.

If both parents have the same birth date, then the plan covering the parent the longest will be primary and the plan covering the parent for the shorter period of time will be secondary.

3. If a claim is made for a Dependent child whose parents are separated or divorced, the following order of benefit determination shall apply.
  - a. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a Dependent of the parent without custody;
  - b. When the parents are divorced and the parent with custody of the

child has remarried, the benefits of a plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a Dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a Dependent of the parent without custody.

Notwithstanding (a) and (b) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a Dependent child.

4. If (1), (2) or (3) do not apply, the plan covering the individual the longest is primary. However, if an individual is laid-off, retired or covered under COBRA, and is covered by two plans, the plan covering the individual as an active employee will be primary and the plan covering the individual as a retired or laid-off employee, or as a COBRA qualified beneficiary will be secondary. This provision also applies to coverage for Dependents of any such individual.

If either plan does not have this provision regarding laid-off or retired employees and COBRA qualified beneficiaries, which results in both plans determining their benefits before the other, or each plan determining their benefits after the other, this provision does not apply, and the order of benefits outlined in the plan that does not have this provision will apply.

## **RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any other plan, the Plan may without the consent of or notice to any persons release to, or obtain from, any insurance company or other organization or person any information with respect to any person which it deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan information as may be necessary to implement this provision.

## **FACILITY OF PAYMENT**

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan, the Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

## **GENERAL INFORMATION**

### **COMPANY**

The Company is The Northern Wisconsin Schools Employee Benefit Plan and Trust.

### **THE PLAN**

The Plan (meaning the organization providing coverage for health services and provisions for the payment of claims) has filed the Master Plan Document in the personnel office, which can be inspected at any time during normal working hours by any Plan Member.

The Plan is maintained pursuant to a collective bargaining agreement. A copy of which may be obtained by Plan Members upon written request and is available for examination in the personnel office at any time during normal working hours by any Plan Member.

### **PLAN MEMBER**

The Plan Member is any eligible Employee or Dependent, who is covered by the Plan.

### **ADMINISTRATOR**

The Administrator as used herein shall be the person or firm responsible for the day to day functions and management of the Plan. The Administrator is the Company.

## **NAMED FIDUCIARY**

The Company is the Named Fiduciary for the Plan. As the Plan's Named Fiduciary, the Company has the authority to control and manage the operation and administration of the Plan, to interpret the terms and provisions of the Plan, and to make final determinations as to participants' eligibility for benefits under the Plan. A participant under the Plan will not receive Plan benefits unless the Company determines that the participant is entitled to such benefits.

## **CLAIMS ADMINISTRATOR**

The Claims Administrator will provide technical services and advice in connection with operation of the coverage and performing other functions. The Claims Administrator is Delta Dental Plan of Wisconsin, P. O. Box 828, Stevens Point, Wisconsin 54481, Phone 800.236.3712.

## **CLAIMS**

All claims and questions regarding claims should be directed to Delta Dental Plan of Wisconsin, P. O. Box 828, Stevens Point, Wisconsin 54481, Phone 800.236.3712.

## **BOOKLETS**

The Company has issued to each Employee an individual booklet, which summarizes the benefits to which the person is entitled, to whom benefits are payable, and the provisions of the Plan affecting the Plan Members. The booklet is intended to satisfy the requirement for a Summary Plan Description as specified in ERISA.

## **ADMINISTRATION OF THE PLAN**

The Plan is administered through the Human Resource Department of the Company. Fiscal records are maintained for a Plan Year ending the last day of each year.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Supervisor.

## **PLAN MODIFICATION AND AMENDMENT**

The Board of Trustees of the Company shall be empowered to amend this Plan or any benefit under this Plan at any time by a written instrument signed by the Board of Trustees. An increase or decrease in Plan benefits will become effective as of the date specified in the Plan or in an applicable amendment.

The Plan will furnish each Plan Member with a summary of any material reductions in covered services or benefits not later than 60 days after the effective date of such change.

## **PLAN TERMINATION**

The Board of Trustees shall be empowered to terminate this Plan or any Benefit under this Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims Incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

## **ASSIGNMENT**

The Plan Member's benefits may not be assigned except by consent of the Company to other than suppliers of medical services.

## **THE PLAN IS NOT A CONTRACT**

The Plan shall not be deemed to constitute a contract between the Company and any Employee or be a consideration for, or an inducement or condition of, the employment of an Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provision of any collective bargaining agreements which may be made by the Company with the bargaining representative of any Employees.

## GENERAL PROVISIONS

### CLAIM PROCEDURES (DENTAL)

The procedures outlined below must be followed by Plan Members ("claimants") to obtain payment of benefits under this Plan.

All claims and questions regarding claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Master Plan Document and summary plan description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion. The Plan Administrator has retained the services of an independent third party administrator, Delta Dental Plan of Wisconsin, Inc. ("Claims Administrator") to provide technical services, including the processing of claims.

Each Plan Member claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator, in its sole discretion may require, written proof that the expenses were incurred and that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

### Definitions

Words which are capitalized in this document are either defined below or in the Master Plan Document (see Definitions of General Terms, General Information and General Provisions) and summary plan description.

#### *Post-service Claims:*

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

### **When Claims Must Be Filed**

Claims must be filed with the Claims Administrator within six months of the date charges for the service were Incurred. However in no event, except in the absence of legal capacity, will claims be accepted later than 12 months from the date the charge in question was Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.**

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan and Plan ID #;
7. The name and home address of the Employee;
8. The Employee's social security number;
9. The name and home address of the patient; and
10. The patient's social security number.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper processing of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the claimant of the request for additional information. Failure to do so will result in claims being declined or reduced.

**NOTE: The Plan does not consider inquiries about benefits, eligibility or the circumstances under which benefits might be paid, to be claims. An inquiry does not become a claim unless the proper claim procedure is followed. Further, questions concerning eligibility for benefits, such as calls from providers of services, are NOT ever considered claims. Requests for advance approval of treatment or supplies are NOT ever considered claims since the Plan does not require advance approval for any services.**

### **Initial Benefit Determination**

The Plan Administrator shall notify the claimant of the initial benefit determination, in accordance with the provisions set forth below. The Plan Administrator will decide the claim within a reasonable period of time, but not to exceed 30 days from the date the claim was received.

This time period may be extended for an additional 15 days for matters beyond the Plan's control, including when a claim is incomplete. The Plan Member will receive a written notice of any extension prior to the expiration of the initial 30 day processing period. The notice will include the reason for the extension, a description of the specific information required and the date by which the Plan Administrator expects to render a decision. The Plan Member will be given 45 days in which to provide the requested information.

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

### **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a claimant with a notice of an adverse benefit determination, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Master Plan Document and summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any dental, medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically/Dentally Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

Requested copies will be provided to the claimant within a reasonable period of time, not to exceed 30 days from the date the Plan receives the written request for copies.

### **Appeal of Adverse Benefit Determinations**

#### **A. Procedures for Review of Adverse Benefit Determinations**

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review relevant documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination. If the claimant does not appeal on time, he/she will lose the right to file suit in court and will have failed to exhaust the Plan's internal administrative appeal procedures, which is generally a prerequisite to bringing suit;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that is independent from the initial adverse benefit determination and is conducted by an appropriate named fiduciary of the Plan who is not the same individual who decided the claimant's initial adverse benefit determination and who is not also that individual's subordinate;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, if an adverse benefit determination is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with an independent health care professional who has appropriate training and experience in the field of medicine or dentistry involved in the medical or dental judgment and who is not the same person as the health care professional consulted in connection with the initial adverse benefit determination; and

6. For the identity of dental/medical/vocational experts consulted in connection with the appeal, even if the Plan did not rely upon their advice.

## **B. Requirements for Appeal**

The claimant must file the appeal in writing within 180 days following receipt of the notice of an initial adverse benefit determination. The claimant's appeal must be addressed as follows and mailed and/or faxed to the following number. Attention: Appeal Department, Delta Dental Plan of Wisconsin, Inc., P. O. Box 828, Stevens Point, Wisconsin 54481. Fax: 715.343.7616. It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee;
2. The name of the claimant;
3. The Employee's social security number;
4. The claimant's social security number;
5. The group name and identification number;
6. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
7. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
8. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

## **C. Notification of Benefit Determination on Review**

The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

**D. Manner and Content of Notification of Adverse Benefit Determination on Review**

The Plan Administrator shall provide a claimant with notification of a Plan's adverse benefit determination on review, in writing or electronically. The notification shall contain the following:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Master Plan Document and summary plan description on which the denial is based;
3. The identity of any dental, medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical/dental judgment, a statement than an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical/dental circumstances, will be provided free of charge upon request;
7. A statement of the claimant's right to bring an action under Section 502(a) of ERISA, following an adverse benefit determination on final review; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or the Plan Administrator."

**E. Decision on Review to be Final**

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied and the Plan's internal review procedures have been exhausted. The decision by the Plan Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

### **Appointment of Authorized Representative**

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. **In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.**

### **EXCHANGE OF INFORMATION**

The Plan will promptly provide to appropriate Federal, state and local law enforcement authorities and to other appropriate health plans:

1. Information indicating a potential violation of civil, criminal, or administrative laws relating to fraud and abuse with respect to health plans.
2. Information requested by Federal, state, or local law enforcement agencies which the agency states is relevant to an investigation, audit, evaluation, or inspection under the Federal Fraud and Abuse Control Program.
3. Information which would assist in the identification of potential violations or assist in the identification of areas requiring investigation, audit, evaluation, or inspection. Such information may include: 1) surveys; 2) quality assurance reviews; 3) provider and patient profiles; 4) utilization review, and 5) other similar analyses.

### **ALTERNATIVE TREATMENT**

The Company has the right to approve coverage for treatment, procedures or facilities that are not normally covered under the Plan, if the Company feels that this alternative treatment, procedure or facility offers a cost-effective method of treating the Plan Member's condition. Such approval in no way obligates the Company to approve such coverage in the future, nor does it obligate the Company to approve of Alternative Treatment for any other Plan Member. Each case will be determined on its own merits.

## **ADMINISTRATIVE PROVISION**

### **QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)**

In accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93), the Plan Administrator must recognize Qualified Medical Child Support Orders (QMCSO). A QMCSO is a medical support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under the Group Plan. A child who is identified in such an order is designated an "alternate recipient" and has the same status and rights as any other child covered under the Plan. Alternate recipient is defined as any child of a Covered Employee who is recognized under a medical child support order as having a right to be enrolled under the Plan. The Plan Administrator must perform the following duties in conjunction with the QMCSO:

1. Notify the Covered Employee and alternate recipient(s) that an order has been received;
2. Inform the Covered Employee and alternate recipient(s) of the Plan's written procedures used in determining if the order is qualified as a QMCSO; and
3. Determine, within a reasonable amount of time, if the order is a qualified QMCSO and promptly notify all interested parties, including the Plan Supervisor.

**NOTE:** A Plan Member may request at any time the Plan's QMCSO procedures.

## **PAYMENTS DIRECTLY TO PROVIDERS**

The Plan may pay a provider directly for Covered Expenses for services provided to a Plan Member. Plan dental expense payments for services received by a child for whom there is a QMCSO in effect, will be made directly to the alternate recipient or the alternate recipient's custodial parent or legal guardian, but only to the extent that the alternate recipient's custodial parent or legal guardian has already paid for the Covered Expenses.

## **OTHER SERVICE PLAN CONTRACTS**

If any Member is covered under more than one Plan, the coverage that would be

provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

### **ENTIRE PLAN, CHANGES**

The Plan including the riders and endorsements, the Schedule of Coverage, the applicable schedules, the attached papers, the application of the Employer, and the individual applications, if any, of the Employees, constitute the entire description of benefits between the parties and any statement made by the Employer or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the benefits or reduce the coverage under the Plan or be used in defense of a claim hereunder unless it is contained in a written application.

No change in the Plan shall be valid unless approved by the Employer and unless such change is endorsed thereon or attached thereto.

### **NOTICE**

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by Worker's Compensation insurance.

### **ERRONEOUS PAYMENT REFUND PROVISION**

Covered Expenses (medical, dental, vision, prescription drugs and/or disability benefits, if applicable), are occasionally paid erroneously by the Plan or Plan Administrator (i.e., paid more than once, conditionally paid pending further review or incorrectly paid under the benefit Plan's terms, conditions, limitations or exclusions). An Employee, Dependent, or health care service provider receiving such an overpayment or erroneous payment shall, upon discovery or notice thereof, return such payment to the Plan within 30 days of discovery or demand. The Plan or Plan Administrator shall have no obligation to secure any other payment of the bill prior to refund by the health care provider, Employee or Dependent. A health care provider may not apply an erroneous or duplicate payment to another bill balance or any other Dependent. The Plan shall have the exclusive right to choose who will repay it for an overpayment or erroneous payment (i.e., including but not limited to the Employee, Dependent, health care service provider, another health benefit plan). If the Plan elects to seek refund from the Employee or Dependent, recovery of the overpaid amount shall, at the Plan's option, be

reimbursed in a lump-sum, time payments or deducted from future-claims presented for processing.

Health care service providers accepting payment for services from the Plan, in consideration of such payments, further agree to submit claims for reimbursement in strict accord with their state's health care practice acts, ICD-9, or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator.

Any paid claims not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur a pre-judgment interest rate of 1 1/2% per month. The Plan shall be entitled to litigation costs and actual attorney fees in the event it becomes necessary to institute suit to recover duplicate or erroneous payments or payments of improperly billed charges.

### **CONFORMITY WITH GOVERNMENT LAW**

If any provisions of this Plan are contrary to any law to which it is subject, such provisions are hereby amended to conform thereto.

### **CLERICAL ERROR**

Clerical errors, such as inaccurate transcriptions of premiums, Effective Dates, termination dates, or such as erroneous mailings, shall not change the rights or obligations of any party under the Plan and shall not operate to grant additional benefits to Members.

### **STATEMENT OF RIGHTS**

As a participant in this Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

#### **Receive Information About the Plan and Benefits**

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls all documents governing the Plan, including contracts and collective bargaining

agreements (if applicable), and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including contracts and collective bargaining agreements (if applicable), and copies of the latest annual report and updated summary plan description. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

1. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions by Plan Fiduciaries**

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

## **Enforce Your Rights**

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim, all within certain time periods.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

The Employee Retirement Income Security Act (ERISA) requires that certain information be furnished to each participant in an employee benefit Plan. Your booklet-certificate and this supplement are the Summary Plan Description for purposes of ERISA.

1. Name of Plan:  
Official name: The Northern Wisconsin Schools Employee Benefit Plan and Trust  
Common name: School District of South Shore, Wisconsin  
(Administrators, Teachers and Central Office Employees)

2. Employer Plan Identification Number:  
IRS# 39-1500407
3. Type of Plan:  
Group Dental Welfare Plan
4. Type of Administration:  
Self-funded Welfare Plan (No insurer is involved in this Plan).
5. Plan Administrator:  
The Northern Wisconsin Schools Employee Benefit Plan and Trust  
c/o CESA #12  
618 Beaser Avenue  
Ashland, WI 54806  
(715) 682-2363
6. Plan Sponsor:  
The Northern Wisconsin Schools Employee Benefit Plan and Trust  
c/o CESA #12  
618 Beaser Avenue  
Ashland, WI 54806  
(715) 682-2363
7. Agent for Legal Services:  
The Northern Wisconsin Schools Employee Benefit Plan and Trust  
c/o CESA #12  
618 Beaser Avenue  
Ashland, WI 54806  
(715) 682-2363

Legal process may also be served upon the Plan Administrator or the Plan Trustee.

8. Sources and Methods of Contributions to the Plan:  
The Employer and the Employee share in the cost of the Plan.

The Employer pays 100% of the monthly premium for full-time Employees and for Employees who work a minimum of 80% of full-time status.

For Employees who work less than 80% of full-time status, the Employer will pay a pro-rated share on the monthly premium based upon the number of hours worked by the Employee.

The Employer's contribution is made from his general assets and the Employee's contribution is made from payroll deductions.

9. Funding Medium:  
All assets are held in trust by the Board of Trustees. Benefits are provided from the Fund's assets for Plan Member's. The Fund's assets are also used to defray reasonable administrative expenses.
10. Ending Date of the Plan's Fiscal Year:  
June 30<sup>th</sup>