DELTA DENTAL®

# PELLA CORPORATION

# GROUP DENTAL PLAN

# Delta Dental PPO Plus Premier™

## SUMMARY PLAN DESCRIPTION

## CLAIMS ADMINISTERED BY
## DELTA DENTAL OF IOWA

Effective Date: 01/01/2020
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# IMPORTANT INFORMATION ABOUT THE PLAN AND THIS SUMMARY

### This is a Summary of the Pella Corporation Group Dental Plan

This booklet is a Summary of the Pella Corporation Group Dental Plan ("**Plan**") as it covers active employees of Pella Corporation and its Participating Employers. This Plan is a component benefit Plan of the Pella Corporation General Welfare Benefits Plan, which contains a number of other component benefit Plans (collectively, the "**Plans**".) Separate summaries are available for the different component benefit Plans.

The Plan operates under a detailed legal Plan document. This Summary is incorporated as part of the detailed legal Plan document. Copies of the Plan document are available for review from the Pella Corporation intranet.

Pella Corporation has engaged Delta Dental of Iowa to act as the "**Claims Administrator**" for this self-funded dental Plan, and to provide its network of dental care provider benefits under the Plan. However, Delta Dental does not insure the benefits under this Plan.

### Participating Employers

Pella Corporation is frequently referred to in the Summary as the *"***Company***"* or the *"***Plan Sponsor***"* or *"***Plan Administrator***"* or *"***group sponsor***"*. Pella Corporation is also a Participating Employer in the **Plan**. Other participating Employers in the *Plan* include certain affiliates of Pella Corporation. Other Participating Employers in the *Plan* include:

- *Pella Windows & Doors, Inc*., a Delaware corporation (operating in Chicago, Illinois);
- *Northern Illinois,* a Delaware corporation (operating in Rockford, Illinois);
- *Pella Windows & Doors, Inc.*, (operating in Detroit, Michigan);
- *Vinyl Northwest, Inc.*, (operating in Portland, Oregon);
- *Distinctive Door Inc., a Texas Corporation (*operating in Wylie, Texas);
- *Pella Windows & Doors – HSC, Inc.*, (operating in Brea, California);
- *PWD – Dallas, PWD Inc.*, (operating in Grapevine, Texas);
- *PWD – Northern California Retail Inc.*, (operating in Berkeley, California);
- *PWD – Orlando, Inc.*, (operating in Longwood, Florida);
- *PWD – Seattle, Inc.*, (operating in Spokane and Seattle, Washington).

### This Summary Describes Current Plan Terms

This booklet describes the Plan in effect January 1, 2020. Some provisions, if noted, may take effect at a later date. Many rights of a Covered Person are determined by the Plan documents in effect on the date their employment terminates.

### Not an Employment Contract

This Summary constitutes neither a contract of employment nor a guarantee of continued employment for any definite period of time.

### Right to Amend or Terminate

The Company may change or discontinue the Plan at any time and for any reason, subject only to limitations that may be imposed by law.

### Right to Interpret

The Company and the Claims Administrator have full discretion to make factual determinations and to interpret the Plan, as described in this Summary. The Company has delegated administrative discretion to the Claims Administrator to determine whether a Covered Person meets the Plan's eligibility requirements and to interpret any provision under the Plan. The Claims Administrator will make determinations regarding dental necessity and dental appropriateness under the plan and may require you to provide information it deems necessary for proper administration of the Plan.

### Oral or Other Unofficial Modifications are Not Permitted

The legal documents governing the Plan cannot be modified by oral statements made by anyone, or by unofficial communications (such as e-mail or mailings). The Plan can only be modified by official Plan amendments.

### Read the Entire Summary

It is important that you read the entire Summary. There are certain rules described in this Summary that you must follow in order for the Claims Administrator to properly administer your benefits. Different rules appear in different sections of the Summary. Reading only portions can be confusing and misleading.

It is important that you understand all parts of this Summary to maximize your benefit Plan. We use the words **you** and **your** to refer to *you* and *your* eligible Covered Person(s) who have enrolled for coverage under this *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 Covered Persons who are enrolled under the Dental Plan. Participants and beneficiaries are sometimes collectively referred to as Covered Persons. The words **we, us**, and **our** *r*efer to the Company.

In this Summary Plan Description we sometimes refer to certain laws and regulations. Laws and regulations can and do change from time to time. If you have a question as to how laws and regulations may apply to your coverage please contact your Plan Sponsor.

If you have general questions regarding the Plan, you may contact the Plan Sponsor. However, if you have specific questions concerning eligibility for and/or the amount of any benefits payable under the **Plan**, you may contact the **Claims Administrator**.

## ELIGIBLE EMPLOYEES AND COVERED PERSONS

### Eligible Covered Persons

Employees of the Participating Employers are eligible to enroll for coverage under this Plan if you are employed in an approved employee classification by a Participating Employer. Spouses and eligible children of enrolled

employees are eligible to be enrolled in the Plan if they meet the definition of spouse or eligible child under the Plan. You remain eligible as long as you continue to work in an approved employee classification by a Participating Employer. You are in an approved employee classification if you are:

- a full-time employee regularly scheduled to work 40 or more hours per week; or
- a part-time employee regularly scheduled to work 20-39 hours per week.

**You are also an *Eligible Covered Person* under the Plan if you are:**

- A former employee subject to the terms of a written employment separation or written severance agreement that provides for continued coverage under the Dental Plan.

- ***Spouse –***
  Spouse is a person of the same or opposite sex to whom you are legally married. For purposes of eligibility under this plan, spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides.

- ***Dependent –***
  A Dependent Child is eligible until the end of the month in which the Dependent Child turns age 26 or maximum age as stated below. The term "**Child**" includes the following Dependents:
  - A natural biological Child;
  - A step Child;
  - A legally adopted Child or a Child legally place for adoption as granted by action of a federal, state or local government agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) temporary Legal Guardianship as ordered by a court:
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMSCO)

To be a beneficiary, a child must meet at least one of the following requirements:

- The child is under age 26.
  - the child's coverage will terminate as of the last day of the month in which he or she reaches age 26 and
  - the child will not be able to re-enroll in coverage unless he/she has a qualifying event.
- The child is a dependent of the child's parent and is totally or permanently disabled, either physically or mentally. If the dependent child is permanently disabled, the disability must have existed before the child was age 26, and the child must have had continuous qualifying dental coverage without a break of 63 days or more since the child turned age 26.

A Dependent 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.

**Please Note:** If both you and your spouse are Participants under this Plan, only one of you may cover your eligible children.

## TYPES OF COVERAGE

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

- With **single coverage**, you are the only one covered.
- With **employee and spouse coverage**, you and your eligible spouse are covered.

- With **employee and child(ren) coverage**, you and your eligible child(ren) are covered.
- With **family coverage**, you and your eligible spouse, and each of your eligible children have coverage and are considered beneficiaries. Each Covered Person must be listed on your dental application for coverage or added later as a new eligible Covered Person.

## EFFECTIVE DATE OF COVERAGE

- Your coverage effective date will depend on your employee classification and whether you enroll as a newly hired eligible employee, during mid-year with a qualifying event or during annual open enrollment period. If your employee classification is full-time or part-time employee and you enroll as a newly hired eligible employee, your effective date for coverage will be the first of the month following your hire date. If your hire date is on the first working day of the month, the coverage will begin immediately.

All required enrollment and other supporting documentation must be completed and submitted to the Plan Sponsor no later than the Wednesday before the date of hire.

- If you enroll during mid-year with a qualifying event, you must notify your site Human Resources Department as required by the **Notification of Change** section and your request for a change in your coverage must be received by your site Human Resources Department within 30 days following your qualifying event causing the change in status. "**Qualifying Event**" is described below under **Coverage Changes**. Changes to your elections are generally effective the first of the month following your qualifying event.

    - Exception: Changes in status due to birth, adoption, or placement for adoption are effective the first of the month in which the qualifying event occurs.

- If you enroll during annual open enrollment period, eligible employees must submit an enrollment form with your elections and your eligible Covered Persons to be covered. "Open Enrollment" means the period of time at the end of the calendar year as chosen by the Plan Sponsor during which qualified employees, eligible spouse, and/or eligible children who are not covered under the Plan may elect to begin coverage or change their current elected coverage, effective on the first day of the next calendar year.

***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 your employer or group sponsor) to release any necessary information requested about you in accordance with applicable law so Delta Dental can process claims for benefits. You must allow any healthcare provider or his or her employees 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 acts on your application, then we may terminate your benefits.

## EFFECTIVE DATE OF COVERAGE

### CHANGES IN STATUS

Normally, you cannot change the elections made in the enrollment period over the course of a year. However, if you have a qualified change in status, you may be able to revoke your previous elections or make a new election. You can only change your coverage in a way that is consistent with a change in status if the change in status results in the gain or loss of eligibility for benefit coverage under the Plan and under a Plan maintained by a Participating Employer or under a Plan maintained by your other Eligible Coverage Person's employer.

### NOTIFICATION OF CHANGE

You must notify the Human Resources Department within 60 days of the date of event that triggers a change in status and provide required evidence verifying the change. You must provide the required evidence to your benefits department within 60 days of its request for this information. If you don't make this request within 60 days, the person affected by the event may not enroll until an annual reopening of the group.

**Please note:** During the group's annual enrollment period, you may also remove your other Covered Persons from your current coverage (with the exception of those under a court order). Those other Covered Persons being removed from the coverage will not be offered the continuation of COBRA. Once a Covered Persons is removed from the Plan, you will not be allowed to add them back onto the Plan without a change in status event, or until the next annual enrollment period. For details, see Changes in Status earlier in this section.

# 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 About The Plan,** the **Summary of Benefits and Payment,** and **Benefits** sections of this Summary Plan Description.

Effective January, 1, 2018, the Annual Maximum increased to $1,500.

| | PPO | PREMIER | NON-PAR |
|---|---|---|---|
| **Deductible*** | $25/$75 | $25/$75 | $25/$75 |
| **Deductible Apply to Check-Ups and Teeth Cleaning** | * No | No | No |
| **Annual Maximum** | $1,500 | $1,500 | $1,500 |
| **Orthodontics Lifetime Maximum** | $1,500 | $1,500 | $1,500 |
| **Benefit Categories** | **Coinsurance** | | |
| **Check-Ups and Teeth Cleaning** (Diagnostic and Preventive Services) | 00% | 00% | 00% |

1. Dental Cleaning (twice per benefit period)
2. Oral Evaluation (twice per benefit period)
3. Fluoride Applications (once every 12 mos. for children under age 19)
4. X-rays
   - Bitewings (once every 12 months)
   - Full-Mouth (once every 5 years)
   - Occlusal and Extraoral (once every 12 months)
5. Sealant Applications (once every 4 yrs for children under age 16)
6. Space Maintainers
7. Emergency Treatment

| | | | |
|---|---|---|---|
| **Cavity Repair and Tooth Extractions** ** | | | |
| (Routine and Restorative Services) | 20% | 20% | 20% |
| 1. General Anesthesia/Sedation<br>2. Restoration of Decayed or Fractured Teeth<br>3. Limited Occlusal Adjustment<br>4. Routine Oral Surgery | | | |
| **Root Canals** ** | | | |
| (Endodontic Services) | 20% | 20% | 20% |
| 1. Apicoectomy<br>2. Direct Pulp Cap<br>3. Pulpotomy<br>4. Retrograde Filling<br>5. Root Canal Therapy | | | |
| **Gum and Bone Diseases** ** | | | |
| (Periodontal Services) | 20% | 20% | 20% |
| 1. Conservative Procedures<br>2. Complex Procedures<br>3. Maintenance Therapy | | | |
| **High Cost Restorations** ** | | | |
| (Cast Restorations) | 50% | 50% | 50% |
| 1. Cast Restorations<br>a. Crowns<br>b. Inlays<br>c. Onlays<br>d. Posts and Cores | | | |
| **Dentures and Bridges** ** | | | |
| (Prosthetics) | | | |
| 1. Bridges | 50% | 50% | 50% |
| 2. Dentures | 20% | 20% | 20% |
| 3. Repairs and Adjustments | 20% | 20% | 20% |
| 4. Dental Implants | 50% | 50% | 50% |
| **Straighter Teeth** | | | |
| (Orthodontics) | 50% | 50% | 50% |

*Deductible for Benefit Categories: Check-Ups and Teeth Cleaning and Straighter Teeth will be waived for all providers.

**Deductible applies for all providers for Benefit Categories: Cavity Repair and Tooth Extractions, Root Canals, Gum and Bone Diseases, High Cost Restorations, Dentures and Bridges.

# GENERAL INFORMATION

Your Delta Dental PPO Plus Premier™ coverage is administered by Delta Dental of Iowa. By encouraging preventive care, this dental program is designed to help contain dental costs. The key component of the Delta Dental PPO program is their panel of Delta Dental PPO Dentists, hereafter referred to as "PPO Panel Dentists." You may seek care from almost any dentist you wish. However, there are usually advantages when you receive services from PPO Panel Dentists or Participating Delta Dental Dentists. "Participating Delta Dental Dentists," in this Summary Plan Description, are dentists who participate with Delta Dental of Iowa's Premier Program or their local Delta Dental Member Company's Premier Program, but do not participate as a PPO Panel Dentist

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 PPO Panel Dentist or a Participating Delta Dental Dentist.

## WHAT YOU SHOULD KNOW ABOUT PPO PANEL DENTISTS

We have contracting relationships with PPO Panel Dentists. Delta Dental's contracts with PPO Panel Dentists include an applicable fee schedule or the Maximum Plan Allowance. See **Understanding Payment Vocabulary** later in this section. This applicable fee schedule or Maximum Plan Allowance usually results in savings to you. When you receive services from PPO Panel Dentists who participate with Delta Dental of Iowa or any other Delta Dental Member Company, all of the following statements are true:

- PPO Panel Dentists agree to accept their local Delta Dental Member Company's PPO Schedule, which may result in savings for Covered Services.
- Your deductible or coinsurance responsibility may be **less** for Covered Services you receive from a PPO Panel Dentist than it would be from a Participating Delta Dental Dentist or a nonparticipating dentist.
- PPO Panel Dentists agree to file claims for you.
- Delta Dental settles claims directly with PPO Panel 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.
- PPO Panel Dentists agree to handle the notification program for you. See **The Notification Program** section.
- PPO Panel Dentists agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) the applicable fee schedule or Delta Dental's Maximum Plan Allowance for Covered Services. See **Understanding Payment Vocabulary** later in this section.

## WHAT YOU SHOULD KNOW ABOUT PARTICIPATING DELTA DENTAL DENTISTS WHO ARE NOT PPO PANEL DENTISTS

Delta Dental has contracting relationships with Participating Delta Dental Dentists. Delta Dental's contracts with Participating Delta Dental Dentists include payment arrangements based on Delta Dental's applicable fee schedule or the Maximum Plan Allowance. See **Understanding Payment Vocabulary** later in this section. The applicable fee schedule or Maximum Plan Allowance usually results in savings to you. When you receive services from Participating Delta Dental Dentists who participate with Delta Dental of Iowa or a Delta Dental Member Company, all of the following statements are true:

- Participating Delta Dental Dentists agree to accept their local Delta Dental Member Company's payment arrangement, which may result in savings for Covered Services.
- Your deductible or coinsurance responsibility may be *more* for Covered Services you receive from a Participating Delta Dental Dentist that is not a PPO Panel Dentist.
- Participating Delta Dental Dentists agree to file claims for you.

- Delta Dental settles claims directly with Participating 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.
- Participating Delta Dental Dentists agree to handle the notification program for you. See **The Notification Program s**ection.
- Participating Delta Dental Dentists agree that he or she will only be paid the lesser of (i) his or her billed charge or (ii) the applicable fee schedule or Delta Dental's Maximum Plan Allowance for Covered Services. See **Understanding Payment Vocabulary** later in this section.

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

When you receive services from nonparticipating (non-par) dentists, you will not receive any of the advantages that Delta Dental contracts with PPO Panel Dentists or Participating Delta Dental Dentists offer. As a result, when you receive services from nonparticipating dentists, all of the following statements are true:

- We do not have contracting relationships with nonparticipating dentists and they do not agree to accept their local Delta Dental Member Company's PPO payment arrangement or any other payment arrangement. This means you are responsible for any difference between your nonparticipating dentist's billed charge and the Delta Dental nonparticipating dentist fee schedule. See **Understanding Payment Vocabulary** in this section.
- Nonparticipating dentists are not responsible for filing your claims.
- Delta Dental settles claims with you, not nonparticipating dentists. However, for Iowa nonparticipating dentists, the payment will be mailed to you, but the check may be payable to the nonparticipating dentist. 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** section.
- 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, PPO Panel Dentists and Participating Delta Dental Dentists incorporate these costs into their normal fees and do not charge an additional fee for "infection control.")
- Nonparticipating dentists do not agree that he or she will only be paid the lesser of (i) his or her billed charge, or (ii) the applicable fee schedule or Delta Dental's Maximum Plan Allowance for Covered Services, as do Participating Delta Dental Dentists in certain situations. See **Understanding Payment Vocabulary** later in this section.

## QUESTIONS DELTA DENTAL ASKS WHEN YOU RECEIVE DENTAL CARE

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

### 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; and
- The treatment is consistent with and meets professionally recognized standards of dental care and complies with criteria adopted by us; and
- 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 services which are more costly than those equally effective for the treatment or maintenance of your teeth and supporting structures, you are responsible for paying the difference.**

### Is the Procedure Subject to Benefit Limitations?

Benefit limitations refer to amounts that are your responsibility based on the terms of the 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 Plan. 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 covered under the Plan 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 dentist's billed charge and the applicable fee schedule or the Maximum Plan Allowance. ***Please note:*** This only applies if you receive services from a nonparticipating dentist.
- Deductible(s) and Coinsurance.

## DELTA DENTAL'S PAYMENT POLICY

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

For example, Delta Dental will send our 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

### Anniversary Date

The Anniversary Date is the renewal date of the contract between your employer or group sponsor and Delta Dental of Iowa.

### 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 covered benefit under your Dental Plan.*

### Covered Person

Covered Person means any individual eligible for dental benefits under a dental program that is insured or administered by Delta Dental (or by a Delta Dental Member Company).

### Covered Services

Covered Services means dental services allowed as a result of being insured by, or included under a dental plan administered by, Delta Dental (or by a Delta Dental Member Company).

### Delta Dental Member Company

Delta Dental Member Company means a company that is an active member or affiliate member of Delta Dental Plans Association, as defined in the Delta Dental Plans Associations Bylaws.

### Maximum Plan Allowance

Maximum Plan Allowance is the amount which Delta Dental establishes as its maximum allowable fee for the dental Covered Services provided by dentist who participate in the Delta Dental Premier Program. For services billed by dentists outside of Iowa, the Maximum Plan Allowance is based on information from that state's Delta Dental Member Company.

The Maximum Plan Allowance is established by Delta Dental for dental services contained in the "Current Dental Terminology" published by the American Dental Association from time to time. It is developed from various sources that may include, but are not limited to, contracts with dentists, the simplicity or complexity of the procedure, the billed charge for the same procedure by dentists in the same geographic area and with similar training and skills, and a leading economic indicator, such as the Consumer Price Index.

### PPO Schedule

PPO Panel Dentists agree he or she will only be paid the lesser of (i) his or her billed charge, or (ii) the PPO Schedule for Covered Services. The PPO Schedule is a reduced fee schedule for certain Covered Services. Some Participating Delta Dental Dentists, who are other than general practice dentists, will be considered PPO Panel Dentists except that their payment will be based on the lesser of their billed charge or the Maximum Plan Allowance rather than on the PPO Schedule. The Participating Delta Dental Dentists who have agreed to be PPO Panel Dentists will be listed in the Delta Dental of Iowa PPO Panel Dentist Directory.

## UNDERSTANDING AMOUNTS YOU PAY TO SHARE COSTS

### Deductible

Deductible is the fixed dollar amount you pay for Covered Services for each Covered Person 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, if applicable. **Please note:** The family deductible is reached from deductible amounts paid on behalf of any combination of Covered Persons.

### Carryover Deductible

It is possible for you to have benefit dollars applied to your deductible in one Benefit Period that also applies to your deductible for the next Benefit Period. This occurs when you receive Covered Services during the last three months (Oct. – Dec.) of the Benefit Period, and benefits are applied towards your deductible. Those deductible accumulations during the last three months of the Benefit Period will carry over as credit to meet your deductible the next benefit period.

### 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 applicable fee schedule or the Maximum Plan Allowance, as the case may be. In general, the percentage of coinsurance you pay depends on the benefit category of the service you receive and participation status of your dentist.

### Benefit Period Maximum or Annual Maximum

The Benefit Period Maximum or Annual Maximum is the maximum benefit each Covered Person is eligible to receive for certain Covered Services in a Benefit Period. The Benefit Period Maximum is reached from claims settled under this Dental Plan in a Benefit Period. This amount is shown on the **Summary of Benefits and Payment** chart at the beginning of this Summary Plan Description.

Services received from **Benefit Category: Straighter Teeth** are excluded from your Benefit Period Maximum.

### Lifetime Maximum

In a Covered Person's lifetime, total benefits are limited by dollar amount for **Benefit Category: Straighter Teeth – Corrective Orthodontics**. 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, please call Delta Dental at 1 (800) 544-0718.

# BENEFITS

Benefits are dentally necessary and dentally appropriate procedures that qualify for payment under this Summary Plan Description.

## 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

Oral evaluations include all types of dentist examinations including preventive examinations, comprehensive examinations, consultations, and problem focused evaluations.
*Limitation:* This evaluation is a benefit only twice per benefit period.

### Topical Fluoride Applications

Professionally administered procedure in which the dental surfaces are coated with a fluoride solution or gel to discourage decay.
*Limitation:* Topical fluoride is a benefit for eligible beneficiaries who are children under age 19 only once every 12 consecutive months.

### X-Rays:

### Bitewing X-Rays

Bitewing is an x-ray that shows the crowns of the upper and lower teeth simultaneously and that is held in place by a tab between the teeth.
*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 or panoramic x-rays are a benefit only once every 5 consecutive years.

### Occlusal X-Rays

Occlusal x-rays capture all the upper and lower teeth in one image while the film rests on the biting surface of the teeth.

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

### Periapical X-Rays

A radiographic image of a tooth, or limited number of teeth, that includes the crown and root portions.

### Temporomandibular Joint Dysfunction (TMD) and Cephalometric X-Rays

An x-ray or a series of x-rays of the jaw or jaw joint to diagnosis Temporomandibular Joint Dysfunction (TMD).
*Limitation:* These x-rays are a benefit only once every 6 consecutive months.

### Sealant/Preventive Resin Applications

Filling decay-prone areas of the chewing surface of molars.
*Limitation:* Sealant/Preventive Resin applications are a benefit for eligible beneficiaries who are children under age 16 only once per permanent first and second molars every 4 consecutive years. **Sealants and Preventive Resins 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

Space maintainers are a fixed or removable appliance placed to maintain space created by premature loss of one or more teeth.

### Emergency Treatment (Palliative Treatment)

Treatment to relieve pain or infection of dental origin.

### Biopsy of Oral Tissue

Oral tissue biopsy is the removal of tissue from the site of lesion for the purpose of microscopic examination.

### Bacteriologic Cultures, Histopathologic Exams, Pulp Vitality Tests

A pulp vitality test is a small electrical current administered to the surface of a tooth suspected to have a nerve problem. The device advises the dentist if there is any injury or inflammatory situation to the nerve of the tooth.

### Diagnostic Casts

Diagnostic cast is a replica of the teeth and tissues made from an impression; also called a study model.
*Limitation:* Diagnostic casts are a benefit only once every 2 consecutive years.

## CAVITY REPAIR AND TOOTH EXTRACTIONS
## ROUTINE AND RESTORATIVE SERVICES

### General Anesthesia/Sedation

*Limitation:* General anesthesia, intravenous, and non-intravenous conscious 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.
*Limitation:* **If you choose a tooth-colored filling to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.**

### 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.

### 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.

### 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.

***Please note:*** You are covered for root canal therapy for two months after your coverage is terminated under this Dental Plan, but only if the tooth or teeth were fully prepared while you or your other eligible Covered Person(s) were covered under this Dental Plan. However, no extended benefits will be paid for treatment or service received on or after the date you or your eligible Covered Person(s) become eligible for other group dental expense coverage.

## 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 after 36 months have elapsed since last dental cleaning (prophylaxis).

### Guided Tissue Regeneration

Services and supplies for regeneration of lost periodontal structures.

### 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 mouth.

### 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 per benefit period 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 may 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**.

### Periodontal Appliances

A dental appliance used to provide periodontal control and stability.

*Limitation:* Periodontal appliances are a benefit to treat periodontal disease only once every 3 consecutive years.

## HIGH COST RESTORATIONS
## CAST RESTORATIONS

***Please note:*** Procedures in this category should receive Delta Dental's review *before* they are performed. See **The Notification Program**.

Procedures in this category are available once per tooth every 5 consecutive years beginning from the date the cast restoration (includes inlays, onlays, post and cores) 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, abrasion, erosion, and abfraction 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.

*Limitation:* **Inlay benefits are limited to the amount paid for a silver (amalgam) filling.** See *Restoration of Decayed or Fractured Teeth*, described under Cavity Repair and Tooth Extractions earlier in this section.

### 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.

***Please note:*** You are covered for cast restorations for two months after coverage is terminated under this Dental Plan, but only if the tooth or teeth were fully prepared while you or your other eligible Covered Person(s) were covered under this Dental Plan. However, no extended benefits will be paid for treatment or service received on or after the date you or your other eligible Covered Person(s) become eligible for other group dental expense coverage.

### Recementation of Cast Restorations
Recementation of an inlay, onlay, or crown that has become loose.
*Limitation:* Benefits are limited to once every 12 consecutive months after 6 months have elapsed since initial placement.

## DENTURES AND BRIDGES
## PROSTHETICS

***Please note:*** Procedures in this category should receive Delta Dental's review *before* they are performed. See **The Notification Program**.

***Please note:*** Dentures, bridges, and dental implants (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.

***Please note:*** You are covered for bridges for two months after coverage is terminated under this Dental Plan, but only if the tooth or teeth were fully prepared while you or your other eligible Covered Person(s) were covered under this Dental Plan. However, no extended benefits will be paid for treatment or service received on or after the date you or your other eligible Covered Person(s) become eligible for other group dental expense coverage.

### Dentures (Complete and Partial)
Replacing missing permanent teeth with a dental prosthesis that is removable.
Denture repair and relining are also covered.
*Limitation:* Relining is available only if performed one year or more after the initial placement of the denture and then once every 2 years thereafter.

***Please note:*** You are covered for dentures for two months after coverage is terminated under this Dental Plan, but only if the master impressions were taken while you or your other eligible Covered Person(s) were covered under this Dental Plan. However, no extended benefits will be paid for treatment or service received on or after the date you or your other eligible Covered Person(s) become eligible for other group dental expense coverage.

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

### Tissue Conditioning

A method of correcting tissue irritation resulting from the wearing of dentures.
*Limitation:* Tissue conditioning will be limited to two per denture every 36 consecutive months.

### Denture Adjustments

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

## Straighter teeth – corrective orthodontics

Corrective Orthodontics services are orthodontic procedures, or directly associated procedures, that move teeth to correct an abnormal dental relationship between and among teeth.

Benefits received for Corrective Orthodontics apply to the Lifetime Maximum.

Limitation: Corrective Orthodontic services for proper alignment of teeth are a benefit only for an Eligible Covered Persons

When a Corrective 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 payments over the course of treatment, providing coverage still exists.

If Corrective Orthodontic treatment is stopped for any reason before it is completed, Delta Dental of Iowa will pay only for Covered Services and supplies actually received.

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

Delta Dental of Iowa 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 coverage.

***Please note:*** You are covered for orthodontic treatment for two months after termination of this Dental Plan, but only if the appliance or bands were first set while covered under this Dental Plan. The amount payable will be the part of the payment that would have been payable had coverage remained in force during the period extended benefits are payable. However, no extended benefits will be paid for treatment or service received on or after the date you become eligible for other group dental expense coverage.

# 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 their toll-free number on the back cover of this Summary Plan Description.

## PLAN EXCLUSIONS

### Anesthesia or Analgesia

You are not covered for local anesthesia or nitrous oxide (relative analgesia) when billed separately from the related procedure.

### Broken or Missed Appointments

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

### 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.

### Desensitizing Medicament or Resin
You are not covered for the application of desensitizing medicament or resin for cervical and/or root surface sensitivity either on a per tooth or per visit basis.

### 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).

### 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.

### 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 (bruxism).

### Periodontal Splinting

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

### Plaque Control Programs, Oral Hygiene Instructions, and Dietary Instructions

You are not covered for services or supplies used for plaque control, oral hygiene, and/or dietary instructions.

### 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.

### 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.

### Termination

Whether or not we have approved a treatment plan, you are not covered for treatment received after the date your coverage terminates subject to your rights under COBRA (see section in this Summary regarding COBRA).

### Treatment By Other Than A Licensed Dentist

You are not covered for services or treatment performed by anyone other than a licensed dentist or his or her employees. Covered Services provided in states where other types of dental providers can practice independently are allowed.

### Treatment in Progress

You may not be covered for services or supplies related to treatment which began prior to the effective date of this Dental Plan.

### 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 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 Dental Dental before you receive the following benefits:

**Complex Periodontal Surgery**
**High Cost Restorations including Crowns, Onlays, and Bridges**
**Dental Implants**

You should also notify Delta Dental before you receive treatment from any benefit category that will exceed $200.

Our 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 us 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 9000*
*Johnston, IA 50131-9000*

## 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 the time limits set forth in the Claims Procedures under the Plan. 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 Plan;
  — you did not receive an independent exam after Delta Dental asked you to; or
  — the procedure is not dentally necessary and dentally appropriate.

### Reconsideration Request of Treatment Plan

If Delta Dental denies a treatment plan, you may submit it with additional documents 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.

P**lease 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 —PPO Panel Dentists and Participating 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 deny 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 Delta Dental or visit their website www.deltadentalia.com. For your convenience, Delta Dental has listed their toll-free number on the back cover of this Summary. If you must file your own claim, send it to the following address:

*Delta Dental of Iowa*
*P.O. Box 9000*
*Johnston, IA 50131-9000*

## 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 *Plan* when combined with the benefits paid under your other coverage will not be more than 100 percent of either our 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 forward 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 We Will Do

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

- The coverage **without coordination of benefits** pays first when both coverage's 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 contract holder** participant pays before the coverage which you have as a plan beneficiary spouse or 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 payment to you or to your Delta Dental Dentists.

#### What You Should Know About Beneficiaries Who Are Children

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

- **Covered by both parents** who are not separated or divorced or if they are, either 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 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.

### Types of Claims

There are four different types of claims under this Plan. The main difference between claim types is the timeframe within which claims (and appeals of claim denials) must be decided.

### Urgent Care Claim

An urgent care claim is a special type of pre-service claim where application of the ordinary period for deciding the pre-service claim could seriously jeopardize your life or health, or in the opinion of a dentist with knowledge of your medical condition, would subject you to severe pain that cannot be managed without the services in question.

### Pre-Service Claim

A pre-service claim is a claim where the Plan requires you to obtain pre-approval before the benefit will be covered, or imposes a financial penalty if you do not obtain pre-approval. If pre-approval is recommended, but not actually required, then the claim is not a pre-service claim,

### Post-Service Claim

A post-service claim is a claim that involves payment or reimbursement for medical care that has already been provided to you. General concerns or complaints about the operation of the Plan or a component plan are also post-service claims.

### Continued Stay Review Claim

In some cases, the Claims Administrator will approve an ongoing course of treatment for you. A continued stay review claim arises when:

- you request an extension of the previously approved period of time or number of treatments, or
- the Claims Administrator reconsiders its earlier decision and shortens the period of time or the number of treatments previously approved.

### Change in Claim Type

The type of claim is determined initially when the claim is filed. A claim may be re-characterized if circumstances change. For example, a claim may originally be an urgent care claim but, if the urgency subsides, it may be re-characterized as a pre-service claim character.

### Timeframes for Responding to Claims

The timeframe for responding to your claim depends on the type of claim involved.

### Urgent Care Claims

You will be notified of the decision as soon as possible under the circumstances, but no later than 72 hours after your claim is received. If your claim did not include all the information necessary to process your claim, you will be notified within 24 hours of the missing information and you will be given at least 48 hours to provide it. Your claim will then be decided within 48 hours of the earlier of:

- the receipt of the missing information, or
- the end of the period of time provided to submit the missing information.

### Pre-Service Claims

You will be notified of the decision within a reasonable time, but no later than 15 days after your claim is received, unless special circumstances beyond the control of the Claims Administrator require a longer period of time for

reaching a decision. If a longer period of time is required, you will be notified within the initial 15-day period and a single extension of up to 15 days may be utilized.

If your pre-service claim did not include the information necessary to process your claim, you will be notified and given at least 45 days to provide the missing information. The timeframe for deciding your claim will be suspended until you provide the missing information. If the missing information is not provided within the time specified, your claim will be decided without that information, which means it will likely be denied.

### Post-Service Claims

You will be notified of the decision within a reasonable time, but no later than 30 days after your claim is received, unless special circumstances beyond the control of the Claims Administrator require a longer period of time for reaching a decision. If a longer period of time is required, you will be notified within the initial 30-day period and a single extension of up to 15 days may be utilized.

If your post-service claim did not include the information necessary to process your claim, you will be notified and given at least 45 days to provide the missing information. The timeframe for deciding your claim will be suspended until you provide the missing information. If the missing information is not provided within the time specified, your claim will be decided without that information, which means it will likely be denied.

### Continued Stay Review Claim

**Reduction or Termination.** If the Claims Administrator decides to reduce or terminate a previously approved course of treatment, you will be given sufficient advance notice so that you will have enough time to file an appeal and receive a decision on your appeal prior to the reduction or termination.

**Request for extension.** If you request an extension of a previously approved course of treatment, your request will be decided using the otherwise applicable timeframes for urgent care, pre-service, or post-service claims. However, if your request involves urgent care and is made at least 24 hours prior to the end of the initially-approved treatment, you will be notified of the decision within 24 hours after your claim is received.

### Notification of Initial Benefit Decision

You will be notified in writing of the decision regarding your claim. (Notification regarding an urgent care claim may be provided orally, with a written follow-up within three days after the oral notice.) If your claim is denied, in whole or in part, you will be given:

- the reason(s) for the denial,
- reference to the specific Plan provision(s) upon which the denial was based,
- a description of any additional material or information necessary for you to perfect your claim,
- a description of the Plan procedures and time limits for appeal,
- an explanation of any internal rule, guideline, protocol, or similar criteria relied upon in denying your claim (or a statement that such information will be provided free of charge upon written request), and
- an explanation of any scientific or clinical judgment as it applies to your circumstances (or a statement that such an explanation is available upon written request).

If your claim is denied in whole or in part, you have the right to appeal the Claims Administrator's decision. Appeal procedures are described later in this section.

### Deemed Denial

If you do not receive a decision on your claim within the timeframes specified earlier in this section, the claim is deemed to be denied and you can proceed to the appeal phase.

## APPEALING DENIED CLAIMS

**You have 180 days to appeal a claim denial.** If all or any portion of your claim is denied and you want to pursue the matter further, you (or your authorized representative) must, within 180 days after you receive the denial, file a written appeal as described below. If you fail to appeal within the specified time, you give up your right to continue to pursue your claim either administratively or in court.

All appeals are subject to review by the Claims Administrator and are subject to special timing rules. These rules are described later in this section.

All appeals should be submitted to the Claims Administrator. Send appeals of claims to:

Delta Dental of Iowa
P.O. Box 9010
Johnston, IA 50131-9010
Telephone (1-800-544-0718)

### Contents of Appeals

Appeals should include at least the following information:

- the identity of the claimant,
- the specific medical condition or symptom at issue,
- the specific treatment, service, or product for which approval or payment is requested, and
- an explanation of why the claim is urgent and needs to be processed on an expedited basis.

Your appeal must be in writing and must be complete at the time you submit it. It must describe all the reasons why you believe the claim denial was in error, and it must include copies of all documents you want the Claims Administrator to consider as part of your appeal. (If you are certain that the applicable document is already in the Claims Administrator's file, you can simply cite to the relevant page or pages of the applicable document). When you file an appeal, you are permitted to supplement the record and submit documents or other information; that was not provided to the Claims Administrator.

**Please Note**: If your appeal is denied and you want to bring a lawsuit, you generally will not be allowed to submit new evidence or make new arguments that you did not make as part of your appeal. Therefore, you should make sure that the administrative record is complete, and that everything you believe supports your position is presented to the Claims Administrator during the initial claim and appeal process.

### Reviewing the Claims Administrator's Records

If you wish, you may review and/or obtain copies of the documents, records, or other information relevant to your claim. If you request copies, they will be provided free of charge.

If the advice of a dental expert was obtained in connection with the initial benefit decision, the name of each expert will be provided upon request, regardless of whether the advice was relied on in making the decision on your claim.

### Timeframes for Deciding Appeals

The date by which your appeal will be decided depends on the type of claim involved.

### Urgent Care Appeals

You will be notified of a decision on the appeal as soon as possible under the circumstances, but not later than 72 hours after your appeal is received. (Notification may be provided orally, with a written follow-up within three days after the oral notice.)

### Non-Urgent Appeals

The Claims Administrator will decide your appeal within 30 days for a pre-service claim or within 60 days for a post-service claim.

If your appeal is denied in whole or in part, you may request in writing the identity of the dental expert who was consulted.

### Continued Stay Review Claim Appeals

For continued stay review claims involving reduction or termination of a previously approved course of treatment, you will receive a decision on your appeal prior to the reduction or termination.

For continued stay review claims involving a request for an extension of a previously approved course of treatment, your appeal will be decided using the otherwise applicable timeframes for urgent care, pre-service, or post-service claims.

### How Appeals are Decided

The Claims Administrator will use the following procedures when deciding an appeal:

The Claims Administrator will consider all the information you submit, whether or not it was submitted or available as part of your initial claim. If your initial claim was denied for a reason involving dental judgment, the Claims Administrator will consult with a dental professional with appropriate training and experience. The consultant will not be the same individual who was consulted, if any during the review of your initial claim or a subordinate of that individual. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

### Notification of Decision on Appeal

You will be notified in writing of the decision regarding your appeal. If your appeal is denied, in whole or in part, you will be given:

- the reason(s) for the denial,
- reference to the specific Plan provision(s) upon which the denial was based,
- an explanation of any internal rule, guideline, protocol, or similar criteria relied upon in denying your appeal (or a statement that such information will be provided free of charge upon written request).
- a statement of your right to sue in federal court, upon written request and free of charge, reasonable access to and copies of all relevant records used in making the decision, and
- an explanation of any scientific or clinical judgment used in applying the terms of the Plan to your medical circumstances (or a statement that such explanation is available upon written request).

### Deemed Denial

If you do not receive a written response to your appeal within the timeframes specified earlier in this section, the appeal is deemed to be denied.

### Legal Action

If your appeal is denied in whole or in part, you have the right to file a lawsuit challenging the denial under section 502(a)(1)(B) of ERISA,29 U.S.C.(§) 1132(a)(1)(B).

**Please note:** You must first exhaust the claims and appeal procedures. The claims and appeal procedures described in this Summary are designed to ensure that disputes regarding the Plan are decided by the Claims Administrator and by Pella Corporation, which are the entities with the most knowledge regarding the proper

operation and interpretation of the Plan. Courts almost always require that you exhaust these claims and appeal procedures before bringing a lawsuit. If you fail to do so, the court will likely dismiss your lawsuit.

### Deadline for Filing a Lawsuit

Any lawsuit challenging a denial of benefits must be commenced within six months after the date on the letter denying the appeal (or the date of the deemed denial).

### Deference to Administrative Decisions

Pella Corporation has full discretion to interpret the terms of the Plan, and the Claims Administrator has full discretion to interpret the terms of the Plan and to determine eligibility for benefits there under. This discretion includes all decisions as to whether you are entitled to benefits and, if so, the amount of your benefits. The decisions of Pella Corporation and the Claims Administrator are to be given deference to the maximum extent permitted by law.

### Other Provisions

### Authorized Representative

You may authorize another person to represent you and with whom you want the Claims Administrator to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in the Claims Administrator's Authorized Representative Form. This form is available by calling the Claims Administrator. In a medically urgent situation, your treating dentist may act as your authorized representative without completion of the Authorized Representative Form. An assignment of benefits does not make your provider an authorized representative. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

### Qualified Medical Child Support Order (QMCSO)

Under federal law, the Plan must provide benefits in accordance with the requirements of a qualified medical child support order ("QMCSO"). A child on whose behalf such an order is issued is called an "alternate recipient" and will be treated as a Participant under the Plan. The court order may not require the Plan to provide any type of benefit not otherwise provided for under the Plan. All QMCSO's must be approved and accepted by the Plan before benefits will be provided to the alternate recipient. If you are subject to a QMCSO you must notify the Plan Sponsor when you are hired or within 30 days after the issuance of the court order. You may obtain a copy of the Plan's QMCSO procedures without charge from the Plan Sponsor.

## COVERAGE TERMINATION

## WHEN BENEFITS END

Your eligibility for coverage will terminate for any of these reasons:

- Your employment terminates (however, you may be eligible for COBRA continuation coverage. See **Coverage Continuation Under Federal Law** - COBRA later in this section).
- You employment terminates due to retirement. If this happens, you may be eligible for a continuation of Retiree coverage, up to age 65.
- You cease to meet eligibility criteria under the Plan.
- The Company terminates the Dental Plan.
- You use your dental benefits fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made.

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.

## COVERAGE CONTINUATION UNDER FEDERAL LAW (COBRA)

This section of your Summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other eligible Covered Person(s) of your family who are covered under this Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage when it may become available to you and your family, and what you need to do to protect the right to receive it. No individual is required to demonstrate insurability to elect COBRA continuation coverage. The *Plan Administrator* is responsible for administering COBRA continuation coverage. To provide any of the notices or other information described in this section, or if you have any questions, contact:

Ceridian COBRA Continuation Services
P O Box 534123
St. Petersburg, FL 33747-4123

### RETIREE CONTINUTION

Delta Dental of Iowa
P. O. Box 9010
Johnston, IA 50131-9010

### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." Generally, a qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, you, your Spouse, and your eligible children may be qualified beneficiaries.

**Employee.** If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your hours of employment are reduced (below hours required for eligibility), including layoff or suspension;
- Your employment ends for any reason other than your gross misconduct; or
- You leave employment due to military service.

**Spouse.** If you are the *Spouse* of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan due to any of the following qualifying events:

- Your Spouse dies;
- Your Spouse's termination of employment (for any reason other than gross misconduct) or your Spouse's hours of employment are reduced (below hours required for eligibility), including layoff or suspension;
- You become divorced or legally separated from your *Spouse*;
- Your Spouse becomes entitled to (actually covered under) Medicare (Part A, Part B, or both); or
- If your Spouse is a retiree, your Spouse's former employer becomes involved in bankruptcy proceedings (in certain case).

**Eligible Children.** Your eligible children will become qualified beneficiaries if they lose coverage under the Plan due to any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's employment is terminated (for reasons other than gross misconduct), or the parent-employee's hours of employment are reduced (below hours required for eligibility), including layoff or suspension;

- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the Dental Plan as an eligible child;
- The parent-employee becomes entitled to (actually covered under) Medicare (Part A, Part B, or both); or
- If the parent-employee is a retiree, the parent-employee's former employer becomes involved in a bankruptcy proceeding (in certain cases).

Qualified beneficiaries must be offered coverage identical to that available to similarly situated individuals covered under the Plan. Generally, this will be the same coverage that the qualified beneficiary had on the day before the qualifying event.

However, a change in the benefits under the Plan for the active employees will also apply to qualified beneficiaries. In addition, qualified beneficiaries must be allowed to make the same choices given to non-COBRA beneficiaries under the Dental Plan, such as during periods of annual enrollment by the Plan.

CERIDIAN, the COBRA Plan Administrator will notify you or your other eligible Covered Person(s) in writing when an event makes continuation of coverage available. CERIDIAN will send this notice within 14 days after coverage would otherwise be lost as a result of the qualifying event (or within 14 days of the Plan Administrator receiving the notice of the qualifying event from you as described later in this section).

**You must notify the Plan Administrator (within 30 days of the date the notice is sent or coverage is lost, whichever is later) of the decision to continue coverage**.

If you get divorced or legally separated or your child loses eligibility for coverage as an eligible child, you must notify the Plan Administrator at the address shown at the beginning of this section within 60 days after the qualifying event occurs. The written notice must state the name of the employee and/or child, the Plans under which they are covered (medical, vision, etc.), the qualifying event, and the date the qualifying event occurred.

**Please note**: It is your responsibility to notify the Plan Administrator of a qualifying event. If you fail to provide notification, the Plan Administrator is not obligated to offer COBRA continuation coverage. Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries.

Then the qualified beneficiary must elect whether or not to continue coverage within 60 days after the date the notice is sent or coverage is lost, whichever is later. A parent or legal guardian can elect coverage on behalf of a minor child.

If you waive your right to elect COBRA continuation coverage, and then change your mind during the 60-day election period described above, you can still elect COBRA by contacting the Plan Administrator. Your election must meet all timing requirements described above. A qualified beneficiary should make certain that an election notice is postmarked on or before the applicable 60-day deadline. If the Plan Administrator does not receive the COBRA Enrollment Form within the required timeframe, proof that the enrollment form was mailed to the proper address within the 60-day period will be required in order to obtain continuation coverage (e.g., by producing a certified mail receipt dated within the required timeframe). If you do not submit a completed COBRA election within the 60-day deadline, you will lose your right to elect continuation coverage.

### Duration of Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or an eligible child losing eligibility as a Covered Person, COBRA continuation coverage lasts up to 36 months. When the qualifying event is the termination of

employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

**Disability Extension.** If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must notify the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

If a determination is made that the disabled individual is no longer disabled, the Plan Administrator must be notified within 30 days after the date that the Social Security Administration determines that the individual is no longer disabled. The notification must be made in writing at the address listed at the beginning of this section.

**Second Qualifying Event.** If your family experiences another qualifying event while receiving COBRA continuation coverage, the Spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and eligible children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a child when that child stops being eligible under the Plan as a child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.

Notices must be sent to the COBRA Plan Administrator at the address shown at the beginning of this section.

COBRA coverage starts on the date you would otherwise lose coverage as a result of the qualifying event, and ends on the earliest of any of the following:

- The end of the 18-, 29- or 36 month period referenced above;
- The date the Company no longer provides health coverage to any of their employees;
- The date premiums for COBRA coverage are not paid (discussed below);
- The date you or your other eligible Covered Peron(s) become covered under another group health care Plan (provided preexisting condition exclusions or limitations under the group health care plan do not apply);
- The date you or your other eligible Covered Person(s) enroll in Medicare (if you as a former employee enroll in Medicare, that may be a second qualifying event for your Spouse and eligible children) except as provided in any written agreement with the Plan Sponsor; or
- The date the disabled person covered under extended disability continuation coverage is determined to be no longer disabled under the Social Security Act.

Under the normal rules of the Plan, coverage may, under certain circumstances, continue beyond the end of the month in which the qualifying event occurs, or at monthly rates for active employees. For example, if you die while employed, your eligible Covered Person(s) may receive coverage for up to six months under the normal rules of the Plan.

**Any extended coverage under the normal rules of the Plan beyond the end of the month in which the qualifying event occurs will count against the period of COBRA coverage (whether it is 18, 29, or 36 months).**

### Coverage Options and Cost

If you and/or your other eligible Covered Persons choose continuation coverage through COBRA, you or your other eligible Covered Persons will be offered the same level of benefits as other Participants. If you are receiving

coverage through COBRA, you may add eligible Person(s) who are acquired through marriage, birth, adoption, or placement for adoption. However, if you declined COBRA, you cannot add coverage at a later date.

You (or your eligible Covered Persons) are responsible for paying the premiums for COBRA continuation as of the first of each month (for coverage for that month). Premiums are 102% of the full cost of active coverage under the Plan, as determined by the Plan actuaries for the year. In situations for which a disability extension is applicable, the Plan may charge up to 150% of the full cost of active coverage under the Plan.

COBRA premiums may be increased each Plan year if the cost to the Plan increases. When you experience a qualifying event, you will be notified of the COBRA premium which will apply in the event you elect COBRA continuation coverage.

Failure to timely pay COBRA premiums will result in a loss of coverage. The first COBRA premium is due no later than 45 days after the date COBRA coverage is elected. (This is the date the COBRA election notice is post-marked, if mailed.) Premiums should be sent to CERIDIAN at the address shown at the beginning of this section. You should pay your premium on or before the due date. However, there is a 31-day grace period for late premiums. If premiums are not paid by the end of the grace period, COBRA coverage is cancelled retroactive to the first of the month and cannot be reinstated.

Payment of COBRA premiums is considered to be made on the date it is sent to the address listed on the COBRA election application. Proof that the premium payment was made and sent to the proper address within the required timeframe will be required in the event that the timeliness of the payment is disputed (e.g., a certified mail receipt).

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated. You must make sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator if you have questions about the correct amount of your first payment.

For the continuation of Retiree coverage, payments should be sent to Delta Dental at the address shown at the beginning of this section.

### Alternate Recipients Under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment with the employer is entitled to the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered an eligible child.

### Trade Adjustment Assistance

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance because they have lost their jobs due to trade-related reasons, such as competition from foreign imports. (Eligibility requires a government certification under the 1974 Trade Act.)

Eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for COBRA continuation coverage. However, you are not eligible for the tax credit if you are covered by other government or private insurance coverage (such as your Spouse's vision Plan).

If you have questions about whether this assistance might apply to you, call the Health Care Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at **www.doleta.gov/tradeact/2002act_index.cfm**.

The Trade Adjustment Act also created a second COBRA election period for eligible individuals. Under this provision, if you did not elect COBRA continuation coverage under the initial COBRA election period described above, you may elect continuation coverage during a second 60-day election period, which begins on the first day of the month when you are determined to be eligible for trade adjustment assistance. However, this election may not be made more than six months after you terminated employment with a Participating Employer.

Any COBRA continuation coverage elected during this special election period will begin with the first day of the special election period, and not on the date health coverage under the Plan originally ended.

#### If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact Pella Corporation at the address shown at the beginning of this section, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.DOL.gov/ebsa.

## OUR RIGHT TO RECOVER PAYMENTS

### PAYMENT IN ERROR

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

### SUBROGATION

Once you receive benefits under the Plan arising from an illness or injury, the Plan Sponsor 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 other eligible Covered Persons agree to all of the following:

- You will let the Plan Sponsor and Claims Administrator know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that the Plan Sponsor or Claims Administrator will need to enforce the Plan Sponsor's rights under the Plan;
- You will do nothing to prejudice the Plan Sponsor's or Claims Administrator's rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining written permission from the Plan Sponsor;
- You must reimburse the Plan Sponsor to the extent of benefit payments made under the Plan if payment is received from the other party or parties;
- In the event you and/or your attorney receive any funds in compensation for your illness or injury, you and your attorney will hold those funds (up to and including the amount of benefits paid by the Plan Sponsor in connection with the illness or injury) as trustee(s) for the Plan Sponsor until the extent of its right to reimbursement or subrogation has been resolved;
- The amount of the Plan Sponsor's subrogation interest shall be paid first from any funds recovered on your behalf from any source, without regard to whether you have been made whole or fully compensated for your losses; and
- The Plan Sponsor will not be liable for payment of any share of attorneys' fees or other expenses incurred in obtaining any recovery, except as expressly agreed in writing.

You and your eligible Covered Person(s) must notify the Plan Sponsor and the Claims Administrator if you have the potential right to receive payment from someone else. You must cooperate with the Plan Sponsor and the Claims Administrator to ensure that their rights to subrogation are protected.

The Plan Sponsor's right of subrogation and reimbursement applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat the Plan Sponsor's right of subrogation if there is any recovery on your claim.

The Plan Sponsor reserves the right to offset any amounts owed to it against any future claim settlement amounts.

Once you receive benefits under this Plan arising from an illness or injury, the 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 other eligible Covered Person(s) agree to all of the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we determine we will need to enforce the Plan's rights;
- You will do nothing to prejudice the 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 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; and
- You must cooperate with Delta Dental to ensure that our rights to subrogation are protected.

## OTHER INFORMATION

### NOTICE

You may send any notice to the Plan and/or contact our Claims Administrator at the following address:

*Delta Dental of Iowa*
*P.O. Box 9010*
*Johnston, IA 50131-9010*

Any notice from us to you is valid when sent to your address as it appears on our records or the address of the group through which you are enrolled.

### 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 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 Dental Plan will be litigated exclusively in the state or federal courts located in the state of Iowa and in no other.

## LEGAL ACTION

No legal or equitable action may be brought against us because of a claim under this Plan, or because of the alleged breach of the terms of this 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 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 Plan, nor will it affect our determination of any benefits paid to you.

### Acquisition by States of Rights of Third Parties

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

# YOUR ERISA RIGHTS

### Your Rights Under ERISA

Your participation in a Plan covered by the Employee Retirement Income Security Act of 1974 (ERISA) entitles you to the following rights and protections.

### Information About Your Plan and Benefits.

You may examine, without charge, at the Plan Administrator's office or other specified locations such as work sites, all documents governing the Plan (including insurance contracts and collective bargaining agreements) and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and updated Summary Plan description. The Plan Administrator may make a reasonable charge for the copies. You may obtain a Summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this Summary annual report.

### Continued Group Health Plan Coverage.

You have a right to continue health care coverage for yourself, spouse or eligible children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your family beneficiaries may have to pay for

such coverage. See Coverage Continuation under Federal Law—COBRA in this Summary. You have a right to reduced or eliminated waiting periods for coverage of preexisting conditions under this group Dental Plan if you have creditable coverage from another Dental Plan. You should be given a Plan of creditable coverage, free of charge, from your group Dental Plan or Dental insurance issuer when you lose coverage, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ends, 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 preexisting condition waiting period for up to 12 months (up to 18 months for a late enrollee) after your coverage enrollment date.

**Prudent Actions by Plan Fiduciaries.**

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

**Enforcement of Rights.**

If your claim for a covered benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain times requirements. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in federal court. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the documents were not sent because of reasons beyond the control of the Plan 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. You may also file suit in federal court if you disagree with the Plan's decision or failure to decide on the qualified status of a domestic relations order or a medical child support order. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Questions.**

If you have any questions about your Plan, you should contact the Plan Administrator, i.e., your employer or group sponsor. If you have questions about this statement or about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries:

Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

# GENERAL INFORMATION ABOUT THE DENTAL PLAN

The following is Plan Identifying information:

| | |
|---|---|
| **Plan Name:** | Pella Corporation General Welfare Benefits Plan<br>(The Pella Corporation Group Dental Plan is a component benefit program under the Pella Corporation General Welfare Benefit Plan). |
| **Type of Plan:** | Group Dental Plan |
| **Type of Administration and Funding:** | Self-funded |
| **Source of Contributions:** | Plan Sponsor and employees pay the costs of the Plan |
| **Plan Year:** | The Plan is a calendar year Plan |
| **Plan Number:** | 502 |
| **Plan Sponsor:** | Pella Corporation |
| **Employer Identification Number:** | 42-0497670 |
| **Plan Administrator and Agent for Service of Legal Process:** | Pella Corporation<br>102 Main Street<br>Pella, IA 50219<br>Telephone Number: (641) 621-1000 |
| **Claims Administrator:** | Delta Dental of Iowa<br>1-800-544-0718<br><br>Hearing Impaired Toll Free: 1-888-287-7312<br><br>www.deltadentalia.com<br><br>claims@deltadentalia.com |
| **Named Fiduciary:** | Pella Corporation<br>102 Main Street<br>Pella, IA 50219<br>Telephone Number: (641) 621-1000 |

**Delta Dental of Iowa**
**P.O. Box 9000**
**Johnston, IA 50131-9000**

**Hearing Impaired Toll Free: 1-888-287-7312**
**Toll Free: 1-800-544-0718**
**Local: 1-515-261-5500**

**www.deltadentalia.com**
**Claims@deltadentalia.com**
**Enrollment@deltadentalia.com**