Fox Valley TECHNICAL COLLEGE®
Knowledge That Works

Dental Plan
Summary Plan Description

Effective January 1, 2015

www.fvtc.edu

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Plan Description Information

1. Proper Name of Plan: Fox Valley Technical College Employee Dental Benefits Plan

2. Plan Sponsor: Fox Valley Technical College

   This Plan is maintained under a collective bargaining agreement. A copy of the agreement may be obtained on written request and is available for examination.

3. Plan Administrator and Named Fiduciary:

   Fox Valley Technical College
   1825 N. Bluemound Drive
   P.O. Box 2277
   Appleton, WI 54912-2277
   Telephone: (920) 735-5600

4. *Employer* Identification Number: 39-1087276
   The Plan number assigned for government reporting purposes is 502.

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

6. Plan benefits described in this booklet are effective August 1, 1984; revised January 1, 1997; revised June 1, 1998; revised September 1, 1998; revised September 1, 1999, revised January 1, 2003, revised January 1, 2006, revised January 1, 2010, revised January 1, 2011, January 1, 2015.

7. The *Plan year* is January 1 through December 31. The fiscal year is July 1 through June 30 of each year.

8. Agent for service of legal process:

   Fox Valley Technical College
   1825 N. Bluemound Drive
   P.O. Box 2277
   Appleton, WI 54912-2277

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

   Delta Dental Plan of Wisconsin
   P.O. Box 828
   Stevens Point, WI 54481-0828
   Telephone: (800) 236-3712

10. The Plan's contributions are made by the *employer*. Benefits under the Plan are provided from the general assets of the *employer.*

11. Each *employee* of the *employer* who participates in the Plan receives a Summary Plan Description, which is this booklet. This booklet will be provided to *employees* by the *employer.* It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

12. The Plan benefits and/or contributions may be modified or amended from time to time, or may be terminated by the Plan Sponsor. Significant changes to the Plan, including termination, will be communicated immediately to participants as required by applicable law.

13. Upon termination of the Plan, the rights of the participants to benefits are limited to claims incurred and payable by the Plan up to the date of termination. Plan assets, if any will be allocated and disposed of for the exclusive benefit of the participating *employees* and their *dependents* covered by the Plan, except that any taxes and administration expenses may be made from the Plan assets.

14. The Plan does not constitute a contract between the *employer* and any *covered person* or will not be considered as an inducement or condition of the employment of any *employee*. Nothing in the Plan will give any *employee* the right to be retained in the service of the *employer*, or for the *employer* to discharge any *employee* at any time. It is provided, however, that the foregoing will not modify the provisions of any collective bargaining agreement which may be made by the *employer* with the bargaining representative of any *employee.* A copy of the collective bargaining agreement will be made available by the *employer* for review, upon written request.

15. This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

Schedule of Dental Benefits

An Important Message About Your Plan!

Services are subject to all provisions of the Plan, including the limitations and exclusions.

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

Predetermination of Benefits

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

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

Optional Treatment

In all cases in which *you* select a more expensive *service* or supply than that which is dentally necessary, the Plan will pay only the portion of the fee for the *service* or benefit which is needed to restore the tooth or dental arch to contour and function. *You* will be responsible for the remainder of the *dentist's* fee.

Covered expenses are payable on a Maximum Plan Allowance (MPA) basis.

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

Schedule of Dental Benefits				
		Premier Plan	**Traditional Plan**	**Basic Plan**
Individual *Maximum Benefit*	Preventive, Basic, Major Restorative, Prosthodontic and Temporomandibular Joint (TMJ) *Services*	$2,000 per *benefit* year	$1,000 per *benefit year*	$500 per *benefit* year
	Deductible	**Coinsurance**		
Preventive *Services*	None	*Covered expense* is payable at 90%.	*Covered expense* is payable at 80%.	*Covered expense* is payable at 100%.
Basic *Services*	None	*Covered expense* is payable at 90%.	*Covered expense* is payable at 80%.	*Covered expense* is payable at 80%.
Major Restorative *Services*	None	*Covered expense* is payable at 80%.	*Covered expense* is payable at 80%.	*Covered expense* is payable at 40%.
Prosthodontic *Services*	None	*Covered expense* is payable at 80%.	*Covered expense* is payable at 80%.	*Not Covered*
Orthodontic *Services*	None	*Covered expense* is payable at 50%.	*Covered expense* is payable at 50%.	*Not Covered*
Individual Lifetime *Maximum Benefit* for Orthodontic *Services*		$2,000	$1,500	*Not Covered*

How to File a Claim

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

Delta Dental Plan of Wisconsin, Inc.
P.O. Box 828
Stevens Point, WI 54481

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

DeltaPremier Dentists

As a Delta Dental subscriber, *you* are free to see any dentist *you* choose on a treatment by treatment basis. If *your* dentist has signed a contract with Delta, he or she has agreed to accept payment directly from Delta on our *Maximum Plan Allowance (MPA).* The DeltaPremier Dentist will charge *you* only for copayments, deductibles and *services* not covered by *your* group contract. After a claim for dental services is filed**,** *you* will receive an Explanation of Benefits form indicating the amount Delta paid to the DeltaPremier Dentist and the amount, if any, *you* owe the dentist.

Noncontracting Dentists

If *your* dentist has not signed a contract with Delta Dental, claim payments will still be calculated on the *MPA* but they will be sent directly to *you* rather than to the dentist. *You* will then need to reimburse *your* dentist through his or her usual billing procedure.

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

For information on Delta Dental dentists, call (800) 236-3712, or visit Delta's Web site at www.deltadentalwi.com

Payment of Claims

The *Plan Supervisor* will make direct payment to the *dentist's* office, if he/she is contracted with Delta Dental Plan of Wisconsin, and *you* will receive a copy of the explanation of payment. If the *dentist* is not contracted with Delta, claim payments will be sent directly to *you* with the explanation of the benefit payment. The *Plan Supervisor* reserves the right to request any information required to determine benefits or process a claim. *You* or the provider of *services* will be contacted if additional information is needed to process *your* claim.

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

Payment of benefits under this Plan will be made in accordance with an assignment of rights for *you* and *your dependents* as required under state Medicaid law.

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

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

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

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

Dental Benefits

This section describes benefits for *covered expenses. Covered expense* means *expense incurred* by *you* for the *services* stated below. The expense must be incurred while *you* are covered for that benefit under the Plan. *Covered expenses* are payable on a *Maximum Plan Allowance (MPA)* at the coinsurance percentages and up to the *Maximum Benefits* shown on the Schedule of Benefits.

Deductible

There is no dental deductible.

Coinsurance

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

Benefits are payable at the applicable percentage rate shown on the Schedule of Benefits each *benefit year,* up to the individual *maximum benefit* as shown on the Schedule of Benefits.

Lifetime Maximum

Lifetime maximum means the maximum amount of benefits available while *you* are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the *covered person***.**

Covered Dental Expenses

Note: There is no frequency limitation on any dental procedure.

Preventive Services

- Oral examinations.
- Full mouth or panorex x-rays.
- Bitewing x-rays.
- Miscellaneous x-rays, including but not limited to periapical (specific area) x-rays.
- Cleanings (prophylaxis).
- Topical fluoride treatments. A prophylaxis performed in conjunction with a fluoride treatment is a separate dental *service*.
- Space maintainers. For fixed appliances to maintain a space created by the permanent loss of a tooth or primary teeth.
- Sealants covered on permanent bicuspids and molars.

Basic Services

- Ancillary. Emergency oral examinations and palliative treatment for relief of dental pain.
- Restorative. Fillings, inlays, other than gold, except as described elsewhere.
- Simple extractions.
- Endodontics. Procedures necessary for root canal treatments, root canal fillings and pulp vitality tests.
- Periodontics. Procedures necessary for treatment of diseases of the tissues supporting the teeth including periodontal cleanings (prophylaxis), periodontal exams and periodontal splinting.
- Actisite. When the *covered person* has had prior periodontal therapy performed and pocket depths are 5mm or greater. Actisite must be performed a minimum of four weeks following active periodontal therapy.
- General anesthesia. When administered by a *dentist* in connection with oral or dental surgery and when *dentally necessary* or necessary due to a medical condition that presents a high risk to the patient.

Major Restorative Services

- Inlays or onlays and their maintenance.
- Crowns, porcelain on semi-precious and porcelain on non-precious and their maintenance.

Limitations for Major Restorative Services

The following Major Restorative Services are payable at 50%:

- Gold foil fillings and their maintenance;
- Gold inlays or onlays and their maintenance; and
- Crowns, gold and porcelain on gold and their maintenance.

Expense incurred for Major Restorative Services performed on other than permanent teeth is not a *covered expense.*

If you are a *late applicant* as defined in this Plan, *you* will not be eligible for coverage under this Pan for Major Restorative Services until the next annual open enrollment period.

Prosthodontic Services

Replacement of a bridge or complete/partial denture.

Maintenance of dentures.

Denture repair.

Procedures to reline and rebase, but not within six months of the initial placement and not more than once in any 24 month period for any *covered person.*

Limitations for Prosthodontic Services

Expense incurred for Prosthodontic Services performed on other than permanent teeth is not a *covered expense.*

There is a twelve (12) month waiting period for dentures from a *covered person's* effective date of coverage under the Dental Plan.

Orthodontic Services

Benefits are payable as shown on the Schedule of Benefits, subject to the individual lifetime maximum benefit for Orthodontic Services. Orthodontic treatment means braces and necessary adjustments.

Expense incurred for:

1. Treatment and appliances for tooth guidance, interception and correction; including appliances and harmful habit appliances.

2. *Services* related to covered orthodontic treatment; including x-rays, extractions, exams and space retainers.

Twenty five percent (25%) of the total case fee will be allowed for the initial down payment. Benefit payments for orthodontic treatment are prorated by *Plan Supervisor* over the treatment period. If for any reason the treatment plan is terminated before completion of the treatment, no further benefits are payable.

Limitations for Orthodontic Services

If you are a *late applicant* as defined in this Plan, *you* will not be eligible for coverage under this Plan for Orthodontic Services until the next annual open enrollment period

Limitations and Exclusions

The Plan does not provide benefits for:

1. Any expense due to a *bodily injury* arising out of *your* employment for wage or profit with any employer, or due to a *sickness* for which *you* are entitled to benefits under any Worker's Compensation Law, Occupational Disease Act or any similar statute. (This does not apply if *you* are a person not subject to such laws);

2. *Services* and supplies:
   a. furnished while *you* are not under the regular care of a *dentist,* or
   b. not authorized or prescribed by a *dentist,* or
   c. for which no charge is made, or for which *you* would not be required to pay if *you* were not covered under this Plan unless charges are received from and reimbursable to the United States Government or any of its agencies as required by law; or
   d. furnished by or payable under any plan or law through any government or any political subdivision (this does not include *Medicare* or Medicaid), or
   e. furnished for a military service connected *sickness or bodily injury* by or under an agreement with a department or agency of the United States Government, including the Department of Veteran Affairs;

3. Any loss caused or contributed to:
   a. war or any act of war, whether declared or not; or
   b. any act of international armed conflict, or any conflict involving armed forces of any international authority;

4. Completion of forms or failure to keep an appointment with the *dentist;*

5. Replacement of lost, stolen or duplicate appliances;

6. Composite fillings on molars;

7. Any *service* which is considered *cosmetic dentistry*, unless such *service* is necessary as a result of an accidental *bodily injury* sustained while covered under this Plan.

8. Preventive control programs including oral hygiene instruction, plaque control or dietary planning, lab tests, anaerobic culture, and sensitivity testing;

9. Appliances or restorations for increasing vertical dimension, restoring occlusion, replacing tooth structure lost by attrition, correction of congenital or developmental malformations, or for implantology techniques;

10. Fees for treatment by other than a *dentist*, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be rendered under the supervision and guidance of the *dentist* in accordance with generally accepted dental standards;

11. Any hospital charges or for *services* of any anesthesiologist;

12. General anesthesia unless administered by a *dentist* in connection with oral and dental surgery and when *dentally necessary* or necessary due to a medical condition that presents a high risk to the patient;

13. Prescription drugs;

14. Major Restorative and Prosthodontic Services on other than permanent teeth;

15. Precision or semi-precision attachments;

16. Any *service,* which as determined by the *Plan Supervisor,* does not offer a favorable prognosis, does not have uniform professional endorsement by the American Dental Association, or is deemed to be experimental in nature;

17. Orthodontic Services unless specified in the Schedule of Benefits;

18. *Services* performed prior to *your* effective date of coverage under the Dental Plan, except that orthodontics are covered for work in progress with benefits payable for *services* performed on and after *your* effective date under the Dental Plan;

19. The extent the expense exceeds the *Maximum Plan Allowance (MPA)* for the *service*, treatment or supply in the locality where furnished;

20. Expenses incurred by *a late applicant* as defined in this booklet:

21. Any *expense incurred* after the date *your* coverage under this Plan terminates;

22. Sterilization/infection control fees;

23. *Services* provided by a person who ordinarily resides in *your* home or who is a *family member;*

24. *Services* payable under the Fox Valley Technical College Employee Health Benefits Plan;

25. *Services* for the extraction of impacted teeth, extraction and initial replacement of natural teeth, oral *surgery,* and x-rays and anesthesia related to these covered *services,* unless specifically described as a *covered expense* under this Plan. Refer to the Fox Valley Technical College Employee Health Benefits Plan for possible coverage of these *services.*

26. *Sickness* or *bodily injury* for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises or any other similar coverage. Payments made by any other coverage will be credited toward any applicable *benefit year* deductible and coinsurance for the year the *sickness* or *bodily injury* was initially sustained;

27. Surgical or non-surgical treatment including but not limited to, splints, appliances, adjustments, dental implants, dental braces, x-rays, anesthesia and therapy, for any jaw joint problem including any temporomandibular joint disorder, craniomaxillary, craniomandibular disorder or other conditions of the joint linking the jaw bone and skull; surgical or non-surgical treatment of the facial muscles used in expression and mastication functions, for symptoms including but not limited to, headaches. Refer to the Fox Valley Technical College Employee Health Benefits Plan for possible coverage of these *services.*

Definitions

Active status means continuous employment at the *employer's* normal place of business, or wherever *you* are required to travel on the job, during a normal work week. A normal work week means working on an active, normal full-time and part-time basis as defined by labor contracts.

Benefit year means a 12 month period of time beginning on January 1 and ending on December 31.

Bodily injury means injury due, directly to an accident and *independent* of all other causes.

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

Covered expense means a *dentally necessary expense incurred* by a *covered person* for the actual fee charged.

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

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

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

Dependent means a covered *employee's*:

1. Legally recognized spouse;

2. Domestic partner; domestic partners are individuals of the same gender, who live together in a long-term relationship of indefinite duration, with an exclusive mutual commitment in which the partners agree to be jointly responsible for each other's common welfare and share financial obligations. The partners may not be related by blood to a degree of closeness which would prohibit legal marriage in the state in which they legally reside;

3. Natural blood related child, step-child, legally adopted child or child placed with the *employee* for adoption, child for which the *employee* has legal guardianship or child of a domestic partner, if the member is legally required to cover the child, whose age is less than the limiting age.

   The limiting age for each *dependent* child is the end of the month he or she attains the age of 26 years. *Your* child is covered to the limiting age regardless if the child is:
   a. Married;
   b. A tax dependent;
   c. A student;
   d. Employed;
   e. Residing with or receives financial support from *you*; or
   f. Eligible for other coverage through employment.

4. A covered *employee's* child whose age is less than the limiting age and is entitled to coverage under the provisions of this Plan because of a *qualified medical child support order*;

5. Grandchild, as long as the *employee's* covered *dependent*, who is the parent of the grandchild, is not yet age 18.

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

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

1. Mentally disabled or physically handicapped;

2. Incapable of self-sustaining employment;

3. Dependent on the covered *employee* for at least 50% support and maintenance; and

4. Unmarried.

You must furnish satisfactory proof to the *Plan Supervisor* that the above conditions continuously exist on and after the date the limiting age is reached. The *Plan Supervisor* may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the *Plan Supervisor*, the child's coverage shall cease on the date such proof is due.

Employee means a person in *active status* and directly employed by or compensated for *services* by *your employer*.

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

Expense incurred means the *Maximum Plan Allowance (MPA)* made for *dentally necessary services* and supplies. The *expense incurred* date is the date the *service* is completed or the date which the teeth are prepared for fixed bridges, crowns, inlays, or onlays and the date the final impression is made for dentures or partials.

Family member means *you* or *your* spouse, or *you* or *your* spouse's child, parent, grandparent, brother or sister or any person related in the same way to *your* covered *dependent.*
Late applicant means an employee and/or an *employee's* eligible *dependent* who applies for dental coverage more than 31 days after the eligibility date.

Maximum benefit means the maximum amount that may be payable for each *covered person,* for *expense incurred.* No further benefits are payable once the *maximum benefit* is reached.

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific covered procedure, including the amounts payable by Delta Dental and payable by the *covered person* (i.e., deductibles and coinsurance). The *MPA* is established by Delta, and it is developed from various sources, such as contracts with *dentists*, input from our dental consultants, the simplicity or complexity of the procedure, and the billed charge for the same procedure by *dentists* in Wisconsin.

To alleviate the problem of insignificant reductions, a "flex" of the *MPA* plus 10% or $7.50, whichever is greater, is used. If the provider's charge exceeds the "flex" guideline, the charge is reduced and paid at the normal *MPA.*

In the event a *qualified practitioner's* or provider's fee is not fully paid, and such person will not accept the *MPA* provided for by the Plan, then the employee may submit the balance to the *Plan Supervisor*. The *Plan Supervisor* will contact the *qualified practitioner* or provider in order to negotiate a settlement of the claim.

If the *Plan Supervisor* cannot settle the claim for the *MPA* or less, then the Plan will only be obligated to pay the *MPA*. Any remaining amounts above the *MPA*, would be the responsibility of the *employee* in accordance with any agreement between the *employee* and the *qualified practitioner* or provider.

In the event of Ancillary Emergency oral examinations and palliative treatment for relief of dental pain where services are received and billed in accordance with the Plan in the United States, the *MPA* provision of the Plan will not apply to services rendered as a result of the emergency treatment by a qualified practitioner or provider, provided the member or their benefit eligible dependent(s) otherwise complies with the terms of the Plan.

In the event of Ancillary Emergency oral examinations and palliative treatment for relief of dental pain where services are received and billed in accordance with the Plan in a country other than the United States, the *MPA* provision will be applied, however the basis for the determination of the maximum allowable fee will be 150% of the maximum allowable fee scheduled based on the geographic area of the main campus of Fox Valley Technical College, provided the member or their benefit eligible dependent(s) otherwise complies with the terms of the Plan.

Plan Supervisor means Delta Dental Plan of Wisconsin, the claims administrator of *your* Plan.

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

Qualified medical child support order means a state court order or judgment, including approval of a settlement agreement which:

1. Provides for support of a covered *employee's* child;

2. Provides for health benefit coverage to the child;

3. Is made under state domestic relations law;

4. Relates to benefits under this Plan; and

5. Is qualified in that it meets the technical requirements of ERISA or applicable state law.

It also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by the Omnibus Budget Reconciliation Act of 1993.

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

Sickness means a disturbance in function or structure of *your* body which causes physical signs or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of *your* body.

Total disability or *totally disabled* means, for *you* or *your* employed covered spouse, during the first twelve months of disability *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from performing each and every material duty of *your* respective job or occupation.

After the first twelve months, *total disability* or *totally disabled* means that *you* or *your* employed covered spouse are at all times prevented by *bodily injury* or *sickness* from engaging in any job or occupation for wage or profit for which *you* or *your* employed covered spouse are reasonably qualified by education, training or experience.

Total disability of an *employee* or employed spouse is the inability to perform each and every duty pertaining to any occupation.

Total disability of a non-employed spouse or a child is the inability to perform the normal activities of a person of similar age.

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

Eligibility and Effective Date of Coverage

These provisions apply to *employees* hired on or after the effective date of this Plan, and to *dependents* who are added on or after the effective date of this Plan.

Open Enrollment

Each year, during a minimum 30 day period as determined by the *employer*, you will have the opportunity to enroll in the dental plan offered by *your employer*. If *you* enroll for dental coverage during this open enrollment, *your* effective date under this Plan will be the following January 1. If *your* completed enrollment forms are received by the Fox Valley Technical College Human Resources Office after the end of the open enrollment period, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period.

Employee Eligibility

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

1. *You* are an *employee* who meets the eligibility requirements of the *employer;*

2. *You* are in *active status.*

Your eligibility date is *your* date of hire, rehire date, or date *you* return from an approved leave of absence. *Employees* on an approved unpaid leave of absence or on layoff who choose not to continue, after the District has completed its contract obligations, any or all of the insurance plans for which they are eligible at their own expense, shall, upon return to work, be treated as a new *employee* for purposes of enrolling in the:

   a. dental plan;

   b. health insurance plan provided the request for reinstatement occurs before the expiration of one year from the date the insurance plan was cancelled.

Employee Effective Date of Coverage

You must enroll on forms furnished and accepted by *Plan Supervisor*.

1. If *your* completed enrollment forms are received by the Fox Valley Technical College Human Resources Office after *your* eligibility date but within 31 days from that date, *your* coverage is effective on *your* eligibility date.

2. If *your* completed enrollment forms are received by the Fox Valley Technical College Human Resources Office more than 31 days after *your* eligibility date, *you* are a *late applicant* and *you* will not be eligible for coverage under this Plan until the next annual open enrollment period.

Employee Delayed Effective Date

If the *employee* is not in *active status* on the effective date of coverage, coverage will be effective the day the *employee* returns to *active status*.

Dependent Eligibility

Each *dependent* is eligible for coverage on:

1. The date the *employee* is eligible for coverage, if he or she has *dependents* who may be covered on that date; or

2. The date of the *employee's* marriage for any *dependent* acquired on that date; or

3. The date of birth of the *employee's* natural-born child; or

4. The date a child is placed for adoption under the *employee's* legal guardianship, or the date which the *employee* incurs a legal obligation for total or partial support in anticipation of adoption; or

5. The date a covered *employee's* child is determined to be eligible as an alternate recipient under the terms of a *qualified medical child support order.*

The covered *employee* may cover *dependents* only if the *employee* is also covered. Check with *your employer* immediately on how to enroll for *dependent* coverage. Late enrollment may result in denial of *dependent* coverage until the next annual open enrollment period.

Dependent Effective Date of Coverage

Each *dependent* must be enrolled on forms furnished and accepted by the *Plan Supervisor*.

Each *dependent's* effective date of coverage is determined as follows:

1. If the completed enrollment forms are received by the Fox Valley Technical College Human Resources Office before the *dependent's* eligibility date or within 31 days after the *dependent's* eligibility date, that *dependent* is covered on the date he or she is eligible.

2. If the completed enrollment forms are received by the Fox Valley Technical College Human Resources Office more than 31 days after the *dependent's* eligibility date, the *dependent* is a *late applicant.* The *dependent* will not be eligible for coverage under this Plan until the next annual open enrollment period.

No *dependent's* effective date will be prior to the covered *employee's* effective date of coverage.

Benefit Changes

Any change made to the Plan is effective on the effective date of the change. If *you* are not in *active status* or if *your dependent(s)* are *totally disabled* on the effective date of the change, the

change will not apply to *you* until *you* return to *active status* or for *your dependent* until he or she is no longer *totally disabled.*

Special Provisions for Not Being in Active Status

Termination of coverage will occur on the last day of the month in which *you* terminate active employment with *your employer,* unless the collective bargaining agreement applies. *You* may be eligible to continue *your* coverage while on approved leave of absence or layoff. Contact *your employer's* Human Resources Office for further information. Also, please refer to the Continuation of Dental Benefits Section of this summary plan description.

Reinstatement of Coverage Following Approved Leave of Absence

If *your* coverage under the Plan was terminated due to a period of service in the uniformed services covered under the Uniformed Services Employment and Reemployment Rights Act of 1994, *your* coverage is effective immediately on the day *you* return to work. Eligibility waiting periods and pre-existing condition limitations will be imposed only to the extent they were applicable prior to the period of service in the uniformed services.

Family and Medical Leave Act (FMLA)

If *you* are granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, *you* and *your* covered *dependents* may continue to be covered under the Plan for the duration of the Leave under the same conditions as other *employees* who are in *active status* and covered by the Plan. If *you* choose to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date *you* return to *active status* immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if *you* had been continuously covered.

Special Enrollment

If *you* previously declined coverage under this Plan for *yourself* or any eligible *dependents*, due to the existence of other health coverage (including COBRA) at the time of initial eligibility, and that coverage is now lost, this Plan permits *you*, *your dependent* spouse, and any eligible *dependents* to be enrolled for dental benefits under this Plan due to any of the following qualifying events:

1. Loss of eligibility for coverage due to any of the following:
    a. legal separation;
    b. divorce;
    c. death;
    d. termination of employment;
    e. reduction in the number of hours of employment;

f. any loss of eligibility after a period that is measured by reference to any of the foregoing;

g. *your* spouse's employer terminates their current dental plan and *you* or *your dependents* do not remain eligible for benefits under any plan which may replace the other plan without interruption of coverage.

However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

2. Employer contributions towards the other coverage have been terminated. Employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

3. COBRA coverage under the other plan has since been exhausted.

The previously listed qualifying events apply only if *you* stated in writing at the previous enrollment the other health coverage was the reason for declining enrollment, but only if *your employer* requires a written waiver of coverage which includes a warning of the penalties imposed on late enrollees.

If *you* are a covered *employee* or an otherwise eligible *employee***,** who either did not enroll or did not enroll *dependents* when eligible, *you* now have the opportunity to enroll *yourself* and/or any previously eligible *dependents* or any newly acquired *dependents* when due to any of the following status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption;
4. Loss of eligibility due to termination of Medicaid or State Children's Health Insurance Program (SCHIP) coverage; or
5. Eligibility for premium assistance subsidy under Medicaid or SCHIP.

You may elect coverage under this Plan provided enrollment is within 31 days from the qualifying event or 60 days from such event as identified in #4 and #5 above. *You* MUST provide proof that the qualifying event has occurred due to one of the reasons listed before coverage under this Plan will be effective. Coverage under this Plan will be effective the date of the qualifying event, unless otherwise specified in this section.

In the case of a *dependent's* birth, enrollment is effective on the date of such birth.

In the case of a *dependent's* adoption or placement for adoption, enrollment is effective on the date of such adoption or placement for adoption.

If *you* apply more than 31 days after a qualifying event or 60 days from such event as identified in #4 and #5 above, *you* are considered a *late applicant* and will not be eligible for coverage under this Plan until the next annual open enrollment period.

Please see *your employer* for more details.

Retiree Coverage

You are eligible to continue coverage under the Dental Plan after *you* retire according to eligibility requirements specified in provisions of applicable collective bargaining agreement(s) and/or FVTC policy.

Contact *your employer* for further information.

Termination of Coverage

Coverage terminates on the earliest of the following:

1. The date the group Plan terminates;

2. The end of the last calendar month for which any required contribution was due and not paid;

3. The date *you* enter full-time military, naval or air service of any country or internal organization;

4. The date *you* fail to be in an eligible class of persons according to the eligibility requirements of the *employer;*

5. For any benefit, the date the benefit is removed from the Plan;

6. For *your dependents*, the date the *employee's* coverage terminates;

7. For a *dependent*, the date the *dependent* enters full-time military, naval or air service of any country or international organization;

8. For a *dependent,* the date such *covered person* no longer meets the definition of *dependent;*

9. The date *you* request termination of coverage to be effective for yourself and/or *your dependents.*

If *you* or any of *your covered dependents* no longer meet the eligibility requirements, *you* and *your employer* are responsible for notifying the *plan supervisor* of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to the *plan supervisor.*

Coordination of Benefits

Benefits Subject to this Provision

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

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

1. *Employer,* trustee, union, *employee* benefit, or other association; or
2. Governmental programs, programs mandated by state statute, or sponsored or provided by an educational institution; or
3. Medical benefits coverage in group and individual automobile "no fault" and group and group-type medical benefits in traditional "fault" type contracts.

This Coordination of Benefits provision does not apply to any individual policies or Blanket Student Accident Insurance provided by or through an educational institution. Allowable expense means any eligible expense, a portion of which is covered under one of the plans covering the person for whom claim is made. Each plan will determine what is an allowable expense according to the provisions of the respective plan. When a plan provides benefits in the form of *services* rather than cash payments, the reasonable cash value of each *service* rendered will be deemed to be both an allowable expense and a benefit paid. No plan will pay more than it would have paid without this provision.

Effect on Benefits

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

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

Order of Benefit Determination

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

1. The Plan has no coordination of benefits provision;

2. The Plan covers the person as an *employee;*

3. For a child who is covered under both parents' plans, the plan covering the parent whose birthday (month and day) occurs first in the calendar year pays before the plan covering the other parent. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined the primary plan;

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

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

5. If a person is laid off or is retired or is a *dependent* of such person, that plan covers after the plan covering such person as an active *employee* or *dependent* of such *employee*. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

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

If a plan other than this plan does not include provisions 3. or 5., then this Plan will ignore those provisions in order to coordinate benefits with the other plan.

Coordination of Benefits with Medicare

In all cases, Coordination of Benefits with *Medicare* will conform with Federal Statutes and Regulations. In the case of *Medicare* each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage (i.e., Part A hospital insurance and Part B voluntary medical insurance) whether or not the individual has enrolled for full coverage. *Your* benefits under the Plan will be coordinated to the extent benefits would otherwise have been paid under *Medicare* as allowed by Federal Statutes and Regulations.

Right of Recovery

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

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations which according to these provisions, owe benefits due for the same allowable expense under any other plan.

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

Recovery Rights

Right of Subrogation

If, after payments have been made under the Plan, *you* or *your* covered *dependent*s have a right to recover damages from a responsible party, the Plan will be subrogated to *your* rights to recover**.** ***You*** or *your* covered *dependent* will do whatever is necessary to enable the Plan to exercise its Right and will do nothing after loss to prejudice it. If the Plan is precluded from exercising its Right of Subrogation, it may exercise its Right to Reimbursement.

Right of Reimbursement

If benefits are paid under the Plan and *you* or *your* covered *dependent* recover from a responsible party by settlement, judgment or otherwise, the Plan has a right to recover from *you* or *your* covered *dependent* an amount equal to the amount it paid.

In consideration for the coverage provided by this Plan, and after *you* file a claim, *you* agree to sign any documents that the Plan considers necessary to enforce its Right of Reimbursement.

The Plan, in exercising its Right of Subrogation or Reimbursement, will not seek to recover more than it paid. The Plan, in exercising its Right of Reimbursement, will not seek to recover more than the amount recovered from the responsible party.

By accepting benefits paid by this Plan, *you* agree the Plan has priority to receive payment for the claims it pays, out of any amount *you* recover.

If it is determined by a court or in arbitration that *you* are not made whole by settlement, judgment or otherwise, then *you* agree the Plan is entitled to a pro-rata portion of the amount *you* recover.

Assignment of Recovery Rights

This Plan contains an exclusion for *sickness or bodily injury* for which there is medical payment/expense coverage provided or payable under any automobile, homeowner's, premises or other similar coverage.

If *your* claim against the other insurer is denied or partially paid, the *Plan Supervisor* will process *your* claim according to the terms and conditions of this Plan. If payment is made by the Plan on *your* behalf, *you* agree to assign to the Plan any right *you* have against the other insurer for any expenses the Plan has paid.

General Provisions

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

Incontestability

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

No statement made by *you* can be contested unless it is in a written form signed by *you.* A copy of the form must then be given to *you* or *your* beneficiary.

Right to Request Overpayments

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

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

Time Limit on Certain Defenses

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

Clerical Error, Misstatement of Age or Gender

If it is determined that information about *you* or *your dependents* was omitted or misstated in error, the amount of coverage for which *you* are properly eligible will be in effect. An equitable contribution adjustment will be made. This provision applies equally to *you* and to the Plan. If the error was determined after six months from the effective date of *your* coverage, no adjustment will be made.

Workers' Compensation Not Affected

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

Physical Examination

The Plan, at its own expense, has the right to have *you* examined as often as a plan deems reasonably necessary while a claim is pending.

Legal Actions

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

Medicaid

This Plan will not take into account the fact that an *employee* or *dependent* is eligible for medical assistance or Medicaid under state law with respect to enrollment, determining eligibility for benefits, or paying claims.

If payment for Medicaid benefits has been made under a state Medicaid plan for which payment would otherwise be due under this Plan, payment of benefits under this Plan will be made in accordance with a state law which provides that the state has acquired the rights with respect to a covered *employee* to the benefits payment.

Workers' Compensation

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

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

Claim Appeal Procedure

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

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

You may have representation throughout the review procedure. A request for a review must be filed within 60 days after receipt of the written notice or denial of a claim. The Plan's full and fair review will be held and a decision rendered by the Plan no later than 60 days after receipt of the request.

If there are special circumstances, the Plan's decision will be made as soon as possible, but no later than 120 days after receipt of the request for review. If such an extension of time is needed, *you* will be notified in writing prior to the beginning of the extension period.

The Plan's decision after *your* review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decisions are based.