Summary Plan Description

Delta Dental PPO

for

PLEXUS CORP.

50109

BASIC PLAN

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I. Plan Description Information

1. Plan Name ("Plan"): Plexus Corp. Group Dental Plan

2. Plan Sponsor:
Plexus Corp.
One Plexus Way
PO Box 156
Neenah, WI 54957-0529

3. Plan Administrator and Named Fiduciary:

Plexus Corp.
One Plexus Way
PO Box 156
Neenah, WI 54957-0529
920-722-3451

4. Plan Sponsor's Employer Identification Number (EIN): 39-1344447.
The Plan number assigned for government reporting purposes is 506.

5. The Plan provides dental benefits for participating employees, certain retirees [if applicable], and their enrolled dependents. The Plan is a self-funded plan, and benefits are payable solely from the Plan Sponsor's general assets. The Plan Sponsor, as Plan Administrator, is responsible for all claims decisions and the payment of the claims.

6. Plan benefits described in this booklet are effective January 1, 2026.

7. The Plan year is January 1 – December 31
The fiscal year is October 1 – September 30.

8. Agent for service of legal process:

Director – Total Rewards
Plexus Corp.
One Plexus Way
Neenah, WI 54957-0529

9. The Claims Administrator is responsible for performing certain delegated administrative duties, including the processing of claims. The Plan has full and final authority on all claim denial disputes. The Claims Administrator is:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
Telephone: 715-344-6087
Toll Free: 800-236-3712

10. The Plan's contributions are shared by the employer and employee. The employer contribution is subject to change each year, depending upon claims experience and Plan expenses. The employer will pay a portion of the total annual premium for employees. Retirees who participate in the Plan will pay 100% of the annual premium for their coverage under the Plan.

11. Each employee participating in the Plan receives a copy of the Plan and the Summary Plan Description, both of which are this booklet. This booklet will be provided by the employer. It contains information regarding eligibility requirements, termination provisions, a description of the benefits provided and other Plan information.

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

13. Upon termination of the Plan, the rights of the covered persons 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 covered persons, 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 and will not be considered as an inducement or condition of the employment of any employee. Nothing in the Plan will give any employee the right to be retained in the service of the employer, or for the employer to discharge any employee at any time.

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

II. Description of Benefits

Delta Dental has been selected by your employer to provide your dental benefits administration. All of us at Delta Dental are pleased to provide this service to you and any dependents you have enrolled. As a participant of this dental Plan, you are free to see any provider you choose on a treatment-by-treatment basis whether or not the provider is included in our Delta Dental PPO Provider Directory. It is important to remember, however, that your out-of-pocket costs may be lower when you see a Delta Dental PPO provider.

Delta Dental PPO Providers

Delta Dental PPO Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept reduced fees for the dental procedures they provide. This reduces your out-of-pocket costs, because you will be responsible only for applicable deductible amounts, copayments and coinsurance for benefits. And because these providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Providers Outside the Delta Dental PPO Network

Delta Dental Premier Providers

Delta Dental Premier Providers have signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge you any amount that exceeds the Maximum Plan Allowance (MPA). However, you are still responsible for deductibles, copayments, coinsurance, and fees for services that are not benefits under this dental Plan.

Noncontracted Providers

If your provider has not signed a contract with Delta Dental of Wisconsin or with another member of the Delta Dental Plans Association, claim payments will still be calculated based on the MPA, but they will be sent directly to you rather than to the provider. You will then reimburse your provider through his or her usual billing procedure. You will be responsible for any amount in excess of the Maximum Plan Allowance, as well as any deductible, copayment, coinsurance, and fees for services that are not benefits under this dental Plan.

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

For information on Delta Dental PPO or Delta Dental Premier Providers, visit Delta Dental's website at www.deltadentalwi.com or call 800-236-3712.

Maximum Plan Allowance (MPA)

Maximum Plan Allowance (MPA) means the total dollar amount allowed under the contract for a specific benefit.

Filing Claims

To file a claim with Delta Dental, simply present your employee identification card to the receptionist at the dental office, or give your member number. Claims must be filed on forms acceptable to Delta Dental.

Predetermination of Benefits

After an evaluation, your provider may recommend a treatment plan. If the services involve crowns, fixed bridgework, partial or complete dentures, or implants, ask your provider to send the treatment plan with x-rays to Delta Dental. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to you and your provider.

The Predetermination of Benefits form is valid for 1 year from the date issued.

Predeterminations are not required, but Delta Dental encourages you to use this service. Should you have any questions about a predetermination, just call us at 800-236-3712.

Before you schedule dental appointments, you should discuss with your provider the amount to be paid by Delta Dental and your financial obligation for the proposed treatment.

Optional Procedures

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive dental procedure that is adequate to restore the tooth or dental arch to contour and function, but only if the more expensive dental procedure is a benefit under your dental Plan. You will be responsible for the remainder of the provider's fee if a more expensive dental procedure is selected or the entire fee if the more expensive dental procedure is not a benefit. The coinsurance and deductible will apply regardless of which dental procedure is selected.

Clerical or Administrative Error

If a clerical error or other administrative mistake occurs, that error will not deprive you of coverage under your dental Plan that you would otherwise have had. A clerical error or other administrative mistake also will not create coverage for you under your Plan if coverage does not otherwise exist.

Summary of Benefits

Group Number: 50109

Effective Date of Program: January 1, 2026

Dependents to Age: 26
Dependents are covered through the end of the month the age limit is reached.

Deductibles:

Per Person, per Benefit Accumulation Period: $50.00
Per Family, per Benefit Accumulation Period: $150.00

Benefit Maximums:

Per Person, per Benefit Accumulation Period: $1000.00

The benefits of your dental Plan will depend on the provider you choose. Delta Dental PPO Providers agree to accept payment based on a reduced schedule, which means your out-of-pocket costs will be less. The coverage percentage listed in the Delta Dental PPO column applies.

Delta Dental Premier Providers agree to not charge you any amount that exceeds the MPA. The coverage percentage listed in the All Other Providers column applies when treatment is provided by Delta Dental Premier Providers or by providers who have not signed any agreements with Delta Dental.

Benefits:	**Delta Dental PPO**	**All Other Providers**
Diagnostic and Preventive Procedures	**100%**	**100%**
Basic Restorative Procedures	**50%***	**50%***
Major Restorative Procedures	**50%***	**50%***
Orthodontic Procedures	**0%**	**0%**

** Deductible applies.*

After you have satisfied the deductible requirements as stated, the program provides payment at the indicated percentage of fees, up to the maximum stated for each eligible person in each Benefit Accumulation Period. A Benefit Accumulation Period is a 12-month period of time over which deductibles (if any) and maximums apply. The Benefit Accumulation Period is January 1 through December 31.

Covered Procedures

Please see the Summary of Benefits page for the coverage percent for each category.

Covered services are subject to the limitations described within each coverage category below and the Exclusions outlined later.

Evidence-Based Integrated Care Plan (EBICP)

Delta Dental's Evidence-Based Integrated Care Plan ("EBICP") is an enhancement that provides expanded benefits for persons with diseases and medical conditions that have oral health implications. To participate in EBICP, eligible dental Plan enrollees or their Providers are required to set the appropriate health condition indicator online at www.deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin.

The EBICP benefits are as follows:

Periodontal Disease

1. With an indicator of surgical or nonsurgical treatment of **Periodontal Disease**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of surgical or nonsurgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Diabetes

With an indicator of a **Diabetes** diagnosis, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

Pregnancy

With an indicator of **Pregnancy**, a participant is eligible for one additional dental visit for adult prophylaxis or periodontal maintenance during the pregnancy.

High Risk Cardiac Conditions

With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:

- History of infective endocarditis
- Certain congenital heart defects (such as having one ventricle instead of the normal two)
- Individuals with artificial heart valves
- Heart valve defects caused by acquired conditions like rheumatic heart disease
- Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
- Individuals with pulmonary shunts or conduits
- Mitral valve prolapse with regurgitation (blood leakage)

Suppressed Immune System Conditions

1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Kidney Failure or Dialysis Conditions

With an indicator for **Kidney Failure or Dialysis Conditions**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

Cancer Related Chemotherapy and/or Radiation

1. With an indicator for **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.
2. With an indicator of **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for topical fluoride application beyond the age limitation in this Summary Plan Description.

Special Health Care Needs Benefit Qualifications

For you or your covered dependent to participate in the Special Health Care Needs Benefits, all of the following must be true for the individual seeking to participate:

1. The individual has Special Health Care Needs;
2. The individual's Special Health Care Needs significantly impair the individual's ability to obtain routine covered dental services; and
3. The individual's provider performs an initial assessment of the individual, concludes the individual satisfies the qualifications for Special Health Care Needs, and submits any requested documentation to Delta Dental. When the provider makes the initial assessment, the provider will assess their need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques to provide treatment. The provider may ask for documentation evidencing the individual's Special Health Care Needs.

"Special Health Care Needs" is any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental causes and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activities.

Special Health Care Needs may include any of the following:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs

- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special Health Care Needs does not include a standalone diagnosis of anxiety, depression, or fear of dentists or dental treatment (odontophobia) which is not part of a covered condition.

Special Health Care Needs Benefits

If you or your covered dependent satisfies the qualifications for the Special Health Care Needs Benefits as outlined in the Special Health Care Needs Qualifications section above, the Covered Procedures subsection of Section II, Description of Benefits, in the Summary Plan Description will be amended as follows for that individual:

1. The individual is eligible for an unlimited number of evaluations beyond any frequency limitations for such benefit in the Summary Plan Description.
2. The individual is eligible for up to two additional dental visits per Benefit Accumulation Period for periodontal maintenance or prophylaxis.
3. Dental case management is added as a benefit for the individual. The deductible and benefit maximums in the Summary of Benefits subsection, if any, apply.
4. Behavior management is added as a benefit for the individual. The deductible and benefit maximums in the Summary of Benefits subsection, if any, apply.
5. Up to four (4) units of general anesthesia is added as a benefit for the individual. The deductible and benefit maximums in the Summary of Benefits subsection, if any, apply.
6. Application of desensitizing medication is added as a benefit for the individual. The deductible and benefit maximums in the Summary of Benefits subsection, if any, apply.

Diagnostic and Preventive Procedures

1. Examinations two per calendar year.
2. Full mouth x-rays, which include bitewing x-rays, at 5-year intervals, unless necessary due to an accidental injury. Full mouth x-rays may be either individual films or panoramic film.
3. Bitewing x-rays at twelve month intervals, limited to a set of 4 films.
4. Miscellaneous x-rays including but not limited to periodical x-rays.
5. Dental prophylaxis (teeth cleaning) two per calendar year
6. Topical fluoride applications two per calendar year, for dependent children to age 19.
7. Space maintainers for retaining space when a primary tooth is prematurely lost.
8. Emergency treatment to relieve pain.
9. Topical application of sealants for dependents to age 19. Application is limited to the occlusal surface of permanent molars that are free of decay and restorations. Benefits are limited to 1 application per tooth per 36 months.

Basic Restorative Procedures

1. Extractions and other oral surgery (cutting procedures), including preoperative and postoperative care.
2. *a*. amalgam (silver) restorations;
   b. composite (tooth-colored) restoration;
   c. stainless steel prefabricated crowns — 1 per tooth in a 3-year period.

3. Local anesthetic as part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery and when dentally necessary or necessary due to a dental condition that presents a high risk to the patient.
4. Endodontics (root canal treatment and root canal therapy).
5. Periodontics (procedures needed to treat diseases of the gums and the bone supporting the teeth — nonsurgical treatment once each 2 years; surgical treatment once each 3 years. Periodontal maintenance — either periodontal maintenance or adult prophylaxis four times per calendar year.
6. Recementation, maintenance and repairs of inlays/onlays crowns and bridges.
7. Maintenance, repairs and adjustments of bridges and partial and complete dentures (within 6 months post installation).
8. Repairs and adjustments to prosthetic appliances.
9. Denture reline and rebase two per calendar year.

Major Restorative Procedures

1. Crowns, inlays or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure as a benefit under this dental Plan.
2. Prosthetics, including fixed bridgework, partial dentures, and complete dentures, or implants to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing prosthetic will be provided only after a five-year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original dental procedure under this dental Plan, unless the result of an accidental injury.

   Fixed bridges, implants, and partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed bridge, or implant and implant-related procedures may be a benefit if no more than two teeth are missing in the dental arch in which the bridge is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch. Porcelain veneers on crowns are benefits on the six front teeth, bicuspids, and upper first molars.

   Coverage for initial replacement of teeth is not limited to those lost while you are covered under this dental Plan.

Orthodontic Procedures – Not Covered

Orthodontic services include orthodontic appliances, treatment, and related services for orthodontic purposes, including evaluation, x-rays, extractions, photographs, study models, etc., for persons eligible as stated on the Summary of Benefits page.

Your coverage includes orthodontic treatment in progress. Delta Dental's payment for orthodontic treatment in progress extends only to the unearned portion of the treatment. Delta Dental will determine the unearned amount eligible for coverage.

If orthodontic treatment is stopped for any reason before it is completed, Delta Dental will pay only for services and supplies actually received. No benefits are available for charges made after treatment stops.

Delta Dental calculates all orthodontic treatment schedules according to the following formula: One-fourth of the total case fee is considered the initial or down payment fee, subject to the coverage percentage, any applicable deductible and the orthodontic maximum benefit stated herein. The remainder of the allowed fee is divided by the total number of months of treatment. Monthly payments are made by Delta Dental at the coverage percent stated on the Summary of Benefits page.

Exclusions

This dental Plan does not provide coverage for the following:

1. Dental procedures, services treatment or supplies provided or commenced prior to the effective date of your coverage under this dental Plan or after the termination date of coverage, unless otherwise indicated;
2. Dental procedures, services treatment or supplies to treat injuries or conditions compensable under worker's compensation or employer's liability laws;
3. Prescription drugs, premedications or relative analgesia;
4. Preventive control programs;
5. Charges for failure to keep a schedule appointment;
6. Charges for completion of forms;
7. Charges for consultation;
8. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a Provider for treatment in any such facility;
9. Charges for treatment of, or services related to, temporomandibular joint dysfunction;
10. Dental procedures, services, treatment and supplies that are determined to be partially or wholly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
11. Crowns placed on covered dependents under age 12, other than prefabricated crowns;
12. Prosthetics placed on covered dependents under age 16;
13. Appliances, restorations, or procedures for: (a) increasing vertical dimension; (b) restoring occlusion; (c) correcting harmful habits; (d) replacing tooth structure lost by attrition, erosion, abrasion, or abfraction; (e) correcting congenital or developmental malformations except in newly born children; (f) replacement, provisional and temporary services; (g) splints, unless necessary as a result of accidental injury;
14. Dental procedures, services, treatment or supplies provided by an individual other than a Provider;

15. Dental procedures, services, treatment or supplies to treat injuries or diseases caused by riots or any form of civil disobedience;
16. Dental procedures, services, treatment or supplies to treat injuries sustained while committing a felony or engaging in an illegal occupation;
17. Dental procedures, services, treatment or supplies to treat injuries intentionally inflicted;
18. Replacement of lost or stolen dentures or charges for duplicate dentures;
19. Dental procedures, services, treatment or supplies in cases for which, in the professional judgment of the attending Provider, a satisfactory result cannot be obtained;
20. Local anesthetic is covered as a part of a dental procedure, service or treatment. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures);
21. If orthodontic procedures are included as benefits under this dental Plan, the repair and replacement of orthodontic appliances is not covered;
22. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided;
23. Sterilization/infection control fees.
24. Precious or semi precious attachments.
25. Osteotomies.
26. Veneers and maintenance/repairs on molar teeth.
27. Athletic mouth guards
28. Stressbreakers.
29. Gold foil fillings, maintenance and repairs.
30. Overdentures and their maintenance and repairs.
31. Dental procedures, services, treatment or supplies excluded as provided in the Summary of Benefits;
32. Dental procedures, services, treatment or supplies not specifically covered under this dental Plan or excluded by Delta Dental rules and regulations, including Delta Dental processing policies, which may change periodically and are printed on the Explanation of Benefits and Explanation of Payment forms.

Coordination of Benefits

Applicability

This Coordination of Benefits (COB) provision applies to this Plan when you or a covered dependent has health care coverage under more than one Plan. "Plan" and "this Plan" as used in this Coordination of Benefits provision are defined below.

If this COB provision applies, the Order of Benefit Determination Rules shall be applied first. The rules determine whether the benefits of this Plan are determined before or after those of another Plan. The benefits of this Plan:

1. shall not be reduced when under the Order of Benefit Determination Rules, this Plan determines its benefits before another Plan, but
2. may be reduced when, under the Order of Benefit Determination Rules, another Plan determines its benefits first. This reduction is described in the section, Effect on the Benefits of this Plan.

Definitions

The following definitions apply to this Coordination of Benefits provision:

"Allowable Expense" means an item of dental expense that is covered at least in part by one or more of the Plans covering the person for whom the claim is made. When a Plan provides benefits in the form of services, the cash value of each procedure provided shall be considered both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a calendar year during which Allowable Expenses are compared with total benefits payable under the policy (without applying COB). It does not include any part of a year during which a person has no coverage under this Plan or any part of a year before the date this COB provision or a similar provision takes effect.

"Plan" means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid, Title XIX, grants to states for medical assistance programs, or the United States Social Security Plan whose benefits, by law, are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under 1. or 2. is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary Plan/Secondary Plan": The Order of Benefit Determination Rules state whether this Plan is a primary Plan or secondary Plan as to another Plan covering the person. When this Plan is a secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When Delta Dental is the secondary Plan, Delta Dental may reduce the benefits under its Plan only when the sum of the following exceeds the total allowable expense in a Claim Determination Period.

1. The benefits the secondary Plan would pay for allowable expenses in the absence of COB; plus
2. The benefits that would be payable under other applicable Plans for allowable expenses in the absence of COB, whether or not claim is made.

The amount by which the secondary Plan's benefits are reduced shall be used by the secondary Plan to pay allowable expenses not otherwise paid, which were incurred during the Claim Determination Period by the person for whom the claim is made. As each claim is submitted, the secondary Plan determines its obligation to pay for allowable expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

When there are more than two Plans covering the person, this Plan may be a primary Plan as to one or more other Plans and may be a secondary Plan as to a different Plan or Plans.

"This Plan" means this dental Plan that provides benefits for dental care expenses.

Order of Benefit Determination Rules

General. When there is a basis for a claim under this Plan and another Plan, this Plan is a secondary Plan, which has its benefits determined after those of the other Plan, unless:

1. the other Plan has rules coordinating its benefits with those of this Plan; and
2. both those rules and this Plan's rules described in subparagraph 2.b. require that this Plan's benefits be determined before those of the other Plan.

Rules. This Plan determines its order of benefits using the first of the following rules, which applies.

1. Nondependent/Dependent. The benefits of the Plan that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.

2. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 3.c. below, when this Plan and another Plan cover the same child as a dependent of different persons, called "parents":
   a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but
   b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer will be determined before those of the Plan that covered the other parent.

   However, if the other Plan does not have the rule described in *a.* but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   a. First, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse of the parent with custody of the child; and
   c. finally, the Plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's dental care expenses or if the court decree states that both parents shall be responsible for the dental care needs of the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents' plan have actual knowledge of those terms, benefits for the dependent child shall be determined according to paragraph 2*b.*

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of a child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. this paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's dependent. 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 4. is ignored.

5. Continuation Coverage.
   a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:
      1) First, the benefits of a Plan covering the employee, member, or subscriber or dependent of an employee, member, or subscriber.
      2) Second, the benefits under the continuation coverage.
   b. If the other Plan does not have the rule described in subparagraph a., and if as a result, the Plans do not agree on the order of benefits, this paragraph 5. is ignored.

6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

   If a covered person is entitled to coverage under a group health care Plan which primarily covers services or expenses other than dental care, and if the covered person first became eligible under the medical and dental Plans on the same date, this dental Plan shall be the secondary payer for those services covered by both Plans.

Effects on the Benefits of this Plan

When this Provision Applies. This "Effects on the Benefits of this Plan" provision applies when, in accordance with the "Order of Benefit Determination Rules" provision above, this Plan is a secondary Plan as to one or more other Plans. In that event, benefits of this Plan may be reduced under this paragraph so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses. Such other Plan or Plans are referred to as "the other Plans" in the "Reduction in this Plan's Benefits" provision below.

Reduction in this Plan's Benefits. The benefits that would be payable under this Plan in the absence of this COB provision will be reduced by the benefits payable for the total allowable expenses in a Claim Determination Period under the other Plans in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

When a Plan provides benefits in the form of services, the cash value of each service rendered will be considered both an expense incurred and a benefit payable.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

No rule in other Plan. If the other Plan does not have rules coordinating benefits with those of this Plan, the benefits of the other Plan are determined first.

Right to Receive and Release Needed Information

Delta Dental has the right to decide the facts it needs to apply these rules. Delta Dental may get needed facts from or give them to any other organization or person without your consent, but only as needed to apply these COB rules. Medical and dental records remain confidential as provided by applicable state and federal law. Each person claiming benefits under this Plan must give Delta Dental any facts it needs to process the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Delta Dental will not have to pay that amount again. The term "payment made" means the cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, it may recover the excess, at its option, from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other organizations.

The "amount of payments made" includes the cash value of any benefits provided in the form of services.

Eligibility and Effective Date of Coverage

Annual Benefits Enrollment

Once annually you will have a choice of enrolling yourself and your eligible dependents in this Plan. You will be notified in advance when the Annual Benefits Enrollment period is to begin and how long it will last. If you decline coverage for yourself or your dependents at the time you are initially eligible for coverage, you will be able to enroll yourself and/or eligible dependents during the Annual Benefits Enrollment Period. Your coverage will not be subject to the pre-existing condition limitation.

Employee Eligibility

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

1. You are an employee that works at least 30 hours per week;
2. You are an employee who meets the eligibility requirements of the employer; and
3. You are in active status.

Hourly – Support: Your eligibility date is your date of hire.

Hourly Employees: Your eligibility date is your date of hire.

Employee Effective Date of Coverage

1. If you complete your enrollment before your eligibility date or within 31 days after your eligibility date, your coverage is effective on your eligibility date.
2. If you complete your enrollment 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 Benefits Enrollment period. Your coverage will be effective on January 1st, following the next Annual Benefits 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 date the employee returns to active status. The employer must notify the Plan Manager in writing of the employee's return to active status.

Covered Dependents

If you are enrolled for family coverage, the following persons are covered under this dental Plan as your dependents:

1. Your lawful spouse;
2. Your children (including any children of your unmarried child until your child is 18 years old), including step and adopted children and children placed for adoption with you, who are less than 26 years of age.
3. Your children, including step and adopted children and children placed for adoption with you, who satisfy all of the following:
   (a) The child is a full-time student, regardless of age; and
   (b) The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education; and
   (c) The child re-enrolled as a full-time student within 12 months of returning from active duty.
4. Dependent children age 26 and over who are incapable of supporting themselves because of physical or mental incapacity that began prior to their 26th birthday or the date you became eligible for this dental plan.

Dependents in military service are not covered by this dental Plan.

Dependents no longer meeting these requirements because of divorce or separation from an eligible employee, or the end of a child's dependency status may elect to continue coverage. Please see the **Federal Continuation Provision (COBRA)** section of this Description of Benefits.

Plan Sponsor reserves the right to require that an enrollee or Covered Employee seeking coverage of a dependent provide written documentation, initially and annually thereafter, that the dependent child satisfies the requirements for coverage under this plan.

Dependent Effective Date of Coverage – When a Change in the Employee's Level of Coverage is Not Required

If the employee wishes to add a newborn dependent to the Plan and a change in the employee's level of coverage is not required, contact your Human Resources representative.

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

If the employee wishes to add a dependent (other than a newborn) to the Plan and a change in the employee's level of coverage is not required, the dependent's effective date of coverage is determined as follows:

1. If you complete your enrollment 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 you complete your enrollment 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 Benefits Enrollment period. The dependent's coverage will be effective on January 1st following the next Annual Benefits Enrollment period.

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

If your dependent child becomes an eligible employee of the employer, he or she is no longer eligible as your dependent and must make application as an eligible employee.

Dependent Effective Date of Coverage – When a Change in the Employee's Level of Coverage is Required

If the employee wishes to add a dependent to the Plan and a change in the employee's level of coverage is required, contact your Human Resources representative.

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

1. If you complete your enrollment 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 you complete your enrollment 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 Benefits Enrollment period. The dependent's coverage will be effective on January 1st following the next Annual Benefits Enrollment period.

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

If your dependent child becomes an eligible employee of the employer, he or she is no longer eligible as your dependent and must make application as an eligible employee.

Medical Child Support Orders

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

A QMCSO is a state court order or judgment, including approval of a settlement agreement that: (a) provides for support of a covered employee's child; (b) provides for dental care coverage for that child; (c) is made under state domestic relations law (including a community property law); (d) relates to benefits under the Plan; and (e) is "qualified" in that it meets the technical requirements of ERISA or applicable state law. QMCSO also means a state court order or judgment that enforces a state Medicaid law regarding medical child support required by Social Security Act ss1908 (as added by Omnibus Budget Reconciliation Act of 1993).

A NMSN is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO that requires coverage under the Plan for the dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order that provides for dental care coverage.

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

Special Provisions for not Being in Active Status

If your employer continues to pay required contributions and does not terminate the Plan, your coverage may remain in force as determined by your employer.

The Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)

Continuation of Benefits

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

Eligibility

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

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

Premium Payment

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

Duration of Coverage

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

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

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

Other Information

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

Special Provisions For Not Being In Active Status

If your employer continues to pay required contributions and does not terminate the Plan, your coverage may remain in force:

1. Until the end of the month during a layoff;
2. Until the end of the month after six months during an approved military leave of absence;
3. Until the end of the approved leave of absence time period as determined by your employer.

Your coverage will remain in active status during an approved leave of absence.

Reinstatement of Coverage Following Inactive Status

If your coverage under the Plan was terminated after a period of layoff, and you are a salaried employee and now returning to work, your coverage is effective immediately on the day you return to work. If your coverage under the Plan was terminated after a period of layoff, or during part-time status, and you are an hourly employee and now returning to work, your coverage is effective the first of the month following the day you return to work. The eligibility period requirement will not be waived with respect to the reinstatement of your coverage.

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 if you are a salaried employee and the first of the month if you are an hourly employee. The eligibility period requirement will be waived with respect to the reinstatement of your coverage.

Family and Medical Leave Act (FMLA)

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

Retiree Coverage

Upon retirement from the company, executive leaders may be offered continued coverage under the Plan for the member and their eligible dependents. Such offering, including duration of coverage and the cost to the member for such coverage, would be at the sole discretion of Plexus. Coverage will terminate for the member and their covered dependents when the retiree reaches age 65.

Special Enrollment

If you previously declined coverage under this Plan for yourself or any eligible dependents, due to the existence of other dental coverage (including COBRA), 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 the coverage due to any of the following:
    a. Legal separation;
    b. Divorce;
    c. Cessation of dependent status (such as attaining the limiting age);
    d. Death;
    e. Termination of employment;
    f. Reduction in the number of hours of employment;
    g. Any loss of eligibility after a period that is measured by reference to any of the foregoing;
    h. Meeting or exceeding a lifetime limit on all benefits;
    i. Plan no longer offering benefits to a class of similarly situated individuals, which includes the employee.

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 dental 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 family status changes:

1. Marriage;
2. Birth; or
3. Adoption or placement for adoption.

You may elect coverage under this Plan provided enrollment is within 31 days from the qualifying event. 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 immediately following 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, you are considered a late applicant and will not be eligible for coverage under this Plan until the next Annual Benefits Enrollment period.

Please see your employer for more details.

Termination of Coverage

Coverage terminates on the earliest of the following:

1. The date the Plan terminates;
2. The end of the period for which any required contribution was due and not paid;
3. The date you enter full-time military, naval or air service, except coverage may continue during an approved military leave of absence as indicated in the Special Provisions for not Being in Active Status provision;
4. The date you fail to be in an eligible class of persons according to the eligibility requirements of the employer; or
5. For all employees, at midnight on the last date of the month following termination of employment with your employer;
6. For any benefit, the date the benefit is removed from the Plan;
7. For your dependents, the date your coverage terminates;
8. For a dependent, the date the dependent enters full-time military, naval or air service;
9. for a dependent, the last day of the month the covered person no longer meets the definition of dependent; or
10. The date your request termination of coverage to be effective for yourself and/or your dependents.
11. For all employees, not eligible for retiree coverage as determined by group, coverage terminates at midnight on the last date of the month following termination of employment with your employer;
12. Your employment stops for any reason, including a job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, the Plan may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below.

- If you are not actively at work due to illness or injury, your coverage may continue, until stopped by your employer. Your coverage will not continue beyond the end of the next policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with your employer.

If you or any of your covered dependents no longer meet the eligibility requirements, you and your employer are responsible for notifying the Plan Manager 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 Manager.

Federal Continuation Provisions (COBRA)

Continued Coverage

If your employer employs more than 20 employees, Title X of the Consolidated Omnibus Budget Reconciliation Act 1985 (COBRA) applies. Under COBRA, if you and your covered dependents were covered under this Plan the day before a Qualifying Event, you are "Qualified Beneficiaries" and may elect continuation of dental coverage under this Plan. COBRA defines a Qualifying Event as:

For the Subscriber:

1. The termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. The reduction of hours to fewer than the minimum required for coverage under this dental Plan.

For Covered Dependents:

1. If the covered dependent is the subscriber's spouse:
   a. Death of subscriber; or
   b. Termination of subscriber's employment, except for reasons of gross misconduct; or
   c. Reduction of subscriber's hours to fewer than the minimum required for coverage under this dental Plan; or
   d. Divorce or legal separation from subscriber; or
   e. Subscriber's Medicare entitlement.

2. If the covered dependent is the subscriber's child:
   a. Child ceases to be a dependent; or
   b. Death of subscriber; or
   c. Termination of subscriber's employment, except for reasons of gross misconduct; or
   d. Reduction in subscriber's hours to less than the minimum required for coverage under this dental Plan; or
   e. Subscriber's Medicare entitlement; or
   f. Parents become divorced or legally separated.

The group must provide notice to a Qualified Beneficiary of the right to elect COBRA continuation coverage.

A covered dependent whose coverage is terminated due to divorce, legal separation or cessation of eligibility for dependent coverage must provide the group with notice of such event within 60 days of its occurrence.

The Qualified Beneficiary must make an election of continuation coverage within 60 days beginning on the later of the date of the Qualifying Event or the date the Qualified Beneficiary receives notice of COBRA election rights. The COBRA election by a subscriber or a subscriber's covered spouse is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the covered beneficiary independently elects COBRA continuation coverage.

If election of COBRA continuation coverage is timely, the coverage begins on the date of the Qualifying Event and ends on the earlier of:

1. Eighteen months for all Qualified Beneficiaries after the subscriber's employment termination or reduction in hours.
2. Twenty-nine months after the Qualifying Event for a subscriber or covered dependent who is determined to be disabled under the Social Security Act prior to the 60th day of COBRA coverage and the disability continues during the rest of the 18-month COBRA coverage period. The disabled Qualified Beneficiary must notify the Plan of the disability determination within the first 18 months of COBRA coverage. Coverage will also be continued for any non-disabled family member who is a Qualified Beneficiary with respect to the same Qualifying Event.
3. For Qualified Beneficiaries other than the subscriber who experience a second Qualifying Event, 36 months after the date of the initial Qualifying Event.
4. The date on which the Qualified Beneficiary receiving continuation coverage fails to make a timely payment of premium. Delta Dental will not reinstate COBRA continuation coverage once terminated for nonpayment of premium.
5. The date on which the group ceases to offer this dental Plan to any of its employees or members.
6. The date on which coverage begins under another group dental plan; however, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.
7. The date the Qualified Beneficiary becomes entitled to Medicare benefits.

The first Premium must be paid to the Group within 45 days of the election of COBRA continuation coverage. Future Premium payments must be paid by the first day of each month.

Under ERISA Section 602(3), premium for a Qualified Beneficiary will not exceed 102% of the single, family, or other applicable monthly Rate in effect for the group, except that the premium for a Qualified Beneficiary who becomes disabled during the first 60 days of COBRA coverage will be 150% of the single, family, or other applicable monthly Rate in effect for the group during months 19 through 29 of COBRA coverage.

If you have any questions about continued dental coverage, the human resources department at your company can help you.

Rights of Recovery (Subrogation)

If expenses are paid on your behalf under this Plan, the Plan is entitled to all rights of recovery you may have against any other person for those expenses to the extent of the Plan's payment. The Plan can subrogate only if you are fully compensated for all damages, taking into consideration your comparative negligence. You must sign and deliver to the Claims Administrator, Delta Dental, any legal papers relating to the recovery, help exercise these rights and do nothing to harm these rights. If you are fully compensated for all expenses, you must repay the Plan to the extent of the Plan's claim payments.

Date: 12/02/2025

III. Claims Procedures

Claims Administrator Liability

Delta Dental serves only as the Claims Administrator for this Plan. In no instance is Delta Dental liable for any conduct, including but not limited to tortious conduct or wrongful acts or omissions, by any person providing services to subscribers and covered dependents under this Plan, including but not limited to providers, dental assistants, dental hygienists, hospitals or hospital employees receiving or providing services. In no instance is Delta Dental liable for services of facilities that, for any reason, are unavailable to a subscriber or covered dependent.

Prior Approval of Benefits

The Plan does not require prior approval of dental procedures; however, you or your provider may request a predetermination of benefits to obtain advance information on the Plan's possible coverage of dental procedures before they are rendered. Payment, however, is limited to the benefits that are covered under the Plan and is subject to any applicable deductibles, copayments, coinsurance, waiting periods, and annual and lifetime benefit maximums.

How to Contest a Claim Denial

Denial of a Claim for Benefits

If you make a claim for benefits under this group dental Plan and your claim is denied in whole or in part, you and your provider, will receive written notification within 30 days after your claim is received, unless special circumstances require an extension of time for processing. The decision will be sent on a form entitled "Explanation of Benefits."

If additional time is necessary for processing a claim for benefits, the Claims Administrator, Delta Dental will notify you and your provider of the extension and the reason it is necessary within the initial 30-day period. If an extension is needed because either you or your provider did not submit information necessary to make a benefits determination, the notice of extension will describe the required information. You will have 45 days from receipt of the notice to provide the specified information.

Appealing a Claim Denial (Filing a Grievance)

If you have questions about the denial of your claim for benefits, please contact Delta Dental at 800-236-3712. Because most questions about benefits can be answered informally, the Plan encourages you first to try resolving any problem by talking with Delta Dental. However, you have the right to file an appeal requesting a formal review of the benefits determination.

To appeal a benefits determination, contact Delta Dental's Benefit Services Department at 800-236-3712, fax your request to 715-343-7616, or mail your request to Delta Dental, P.O. Box 828, Stevens Point, WI 54481. Provide the reasons why you disagree with the benefits determination and include any documentation you believe supports your claim. Be sure to include the subscriber's name, the covered dependent's name if applicable, and the subscriber's member number on all supporting documents.

You must make your request within 180 days of the date of the initial benefits determination denying your claim for benefits.

Delta Dental will acknowledge your written request for review within five days of receiving it. Upon your request, Delta Dental will provide you, free of charge, access to and copies of all documents, records, and other information relevant to your claim for benefits.

Within 30 days of receiving your request, Delta Dental will send you the written decision and indicate any action taken. (Special circumstances may require 60 days.)

You have the right to appear in person before Delta Dental's Grievance Committee to present written and oral information and ask questions of the persons responsible for the determination that resulted in the grievance. Delta Dental will provide you with written notice of the meeting place and time at least seven days before the meeting.

Delta Dental will provide you or your authorized representative with written notice of the decision on the appeal. If the appeal is denied in whole or in part, that notice will include the following information.

1. The specific reason(s) for the denial of the appeal;
2. Reference to the specific Plan provision(s) on which the denial is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim;
4. A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;
5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;
6. If the denial of the appeal was based on a dental necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
7. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency."

If you do not exhaust the appeal procedures described above, and if you file a lawsuit seeking payment of benefits, the court may not permit you to go forward with your lawsuit because you failed to utilize these claims appeal procedures. Also, no legal action can be brought later than three years after the date of the final decision on the review of the benefits determination.

If you have any questions, please contact the Claims Administrator:

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
800-236-3712 or 715-344-6087

IV. Statement of ERISA Rights

As a covered person in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all covered persons in the Plan shall be entitled to:

Receive Information about Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each employee or retiree with a copy of the Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the sections of this Plan and Summary Plan Description governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare 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 time schedules.

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 from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a

medical child support order, you may file suit in federal court. 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 Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 your 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.