

**Self Funded Dental Plan
Plan Document
For**

Hope Haven Area Development Center Corporation

Effective November 1, 2006

Amended and Restated January 1, 2011

ADMINISTERED BY



EMPLOYEE BENEFIT SYSTEMS
HELPING ADMINISTER YOUR SUCCESS

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**SELF FUNDED DENTAL PLAN
HOPE HAVEN AREA DEVELOPMENT CENTER CORPORATION**

Article 1 INTRODUCTION

Hope Haven Area Development Center Corporation (the "Employer") has established a Self Funded Dental Plan (called the "Plan") for the benefit of its eligible, full-time employees, their spouses, and eligible dependents. The Plan is to be known as the Hope Haven Area Development Center Corporation, Self Funded Dental Plan.

The provisions of the Plan shall be effective as of January 1, 2011.

This document is the primary source of information about your benefit program under the Plan. It serves as the Plan Document and Summary Plan Description. These benefits, including information about who is eligible to receive benefits, are summarized in this document.

Claims for reimbursement of dental benefits under the Plan are administered by Employee Benefit Systems ("EBS").

SUMMARY OF BENEFITS AND PAYMENT

Self Funded Dental Plan

Sponsored by Hope Haven Area Development Center Corporation

The information on this page summarizes your benefits and payment obligations.

Class I-Diagnostic & Preventative Care

Plan Pays 100% (not subject to deductible)

Class II-Basic Restorative Care

Plan pays 80%

Class III-Major Restorative Care

Plan pays 50%

Class II & III Deductible

Individual: \$25 per calendar year

Family: maximum of three deductibles (\$75) per family per calendar year

Class I, II, and III Combined Calendar Year Maximum

This plan will pay up to \$1,000 per eligible person per calendar year for covered benefits.

If you or any one of your dependents incurs covered expenses the Plan will:

- Deduct any dental deductible that applies from the covered expenses; and
- Pay for the other covered expenses incurred in that calendar year up to the maximum covered expense determined from the dental services schedule for each dental service, subject to the alternate benefit provision.

Benefits

Class I Services-Diagnostic and Preventive

The maximum covered expense for any Class I Service is 100% of the reasonable and customary charge.

- *Dental Cleaning (Prophylaxis)*: Removing plaque, tartar (calculus), and stain from teeth. Limitation: Dental cleaning is a benefit only twice per benefit period at 6 month intervals.
- *Oral Evaluations*: Limitation: This evaluation is a benefit only twice per benefit period at 6 month intervals.
- *Topical Fluoride Applications*: Limitations: Topical fluoride application as prescribed by the Dentist, but not more than once in any 6 month interval.
- *Bitewing X-Rays*: Limitation: These x-rays are a benefit only once every 12 consecutive months.
- *Full-Mouth X-Rays*: Full-mouth x-rays include a combination of individual x-rays such as periapical, bitewing or occlusal taken by a dentist on the same service date. Limitation: Full-mouth x-rays are a benefit only once every 3 consecutive years, unless special need is shown.

Class II-Routine and Restorative Services, Oral Surgery

The maximum covered expense for any Class II Service is 80% of the reasonable and customary charge.

- *Emergency Treatment (Palliative Treatment)*: Treatment to relieve pain or infection of dental origin when no other definitive services are performed. (Any X-ray taken in connection with such treatment is a separate dental service.)
- *General Anesthesia/Sedation*: Limitation: General anesthesia and intravenous sedation administered by a dentist or an employee of the dentist are benefits only when provided in conjunction with covered oral surgery and when billed by the operating dentist.
- *Restoration of Decayed or Fractured Teeth*: Pre-formed or stainless steel restorations and restorations such as silver (amalgam) fillings, and tooth-colored (composite) fillings. Limitation: If you choose a tooth-colored filling to restore back (posterior) teeth, benefits are limited to the amount paid for a silver filling. You are responsible for paying the difference.
- *Routine Oral Surgery*: Including removal of teeth, and other surgical services to the teeth or immediate surrounding hard and soft tissues that are being performed due to disease, pathology, or dysfunction of dental origin. Includes pre and post operative care.
- *Non-surgical periodontics* (treatment for diseases of the gums).

- *Endodontics (pulpal therapy and root canal fillings.)*
- *Surgical periodontics (surgical procedures necessary for the treatment of diseases of the gingival (gums) and supporting teeth).* Please Note: Procedures in this category should receive Employee Benefit Systems' review before they are performed. See the "Notification Program" in Article 5.

Class III Services-Major Restoration, Dentures, and Bridgework

The maximum covered expense for any Class III Service is 50% of the reasonable and customary charge.

Prosthetics- Bridges, crowns, partial and complete dentures, except:

- Limited to once in 3 consecutive years and only if the existing appliance is not and cannot be made satisfactory.
- The 3-year period required by this provision will begin on the date the appliance was last supplied, provided:
 - The covered person was covered under this or a prior plan of the employer at the time the appliance was supplied;
 - The covered person has been continuously covered under this Plan or the Plan and a prior plan of the employer since the appliance was supplied.

Services Not Covered. This Plan does not provide benefits for dental treatment listed in this section. Please note: Even if the treatment is not specifically listed as an exclusion, it may not be covered under this Plan. Call Employee Benefit Systems if you are unsure if a service is covered.

Covered expenses will not include, and no payment will be made for expenses incurred for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of injury;
- any replacement of a bridge, crown, or denture which is or can be made useable according to common dental standards;

5. procedures, appliances, or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontal involved teeth; or (d) restore occlusion;
6. porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second, and third molars;
7. bite registrations; precision or semi-precision attachments; or splinting;
8. a surgical implant of any type, including any prosthetic device attached to it;
9. orthodontic services or supplies;
10. instruction for plaque control, oral hygiene and diet;
11. dental services that do not meet common dental standards;
12. services that are deemed to be medical services;
13. services and supplies received from a hospital;
14. expenses that may be paid or reimbursed by any government or any other political subdivision, instrumentality or agency thereof; except for expenses incurred by a veteran for a non-service-related disability in a facility operated by the United States government;
15. expenses incurred solely because coverage exist or for which the patient has no legal obligation to pay, and expenses incurred prior to the period this Plan was effective;
16. services performed by any member of a claimant's immediate family (spouse, parent, brother, sister, or child) or a person who resides in the claimant's house; or
17. experimental procedures, treatment, services or supplies performed solely for research purposes.

If a medical plan or prepaid treatment program sponsored by the Employer also covers the dental services that were provided, payments under this Plan will be reduced, if necessary, to ensure that no more than 100 percent of the charges are paid.

Article 2 DEFINITIONS

Defined terms shall be capitalized in this Plan. As used in this Plan Document, the following terms shall have the following meanings:

2.1 "We, Us, Our, and the Plan" means Hope Haven Area Development Center Corporation Self Funded Dental Plan.

2.2 "Dentist" means any dentist licensed to practice dentistry. A dentist also means any physician licensed to practice medicine and surgery that is performing procedures common to both the medical and dental professions. This includes both doctors of medicine and doctors of osteopathy.

2.3 "Maximum Allowable Charges (MAC)" means the maximum amount on which the Plan's reimbursements will be based.

2.4 "Certified Registered Nurse Anesthetist (C.R.N.A.)" means a registered Nurse certified to administer anesthesia, who is employed by and is under the personal supervision of a physician anesthesiologist.

2.5 "Covered Expense" means expenses incurred by or on behalf of you or any one of your dependents for charges made by a dentist for the performance of a dental service listed in the *Summary of Benefits*.

2.6 "Treatment Plan" means a written report prepared by a dentist showing the dentist's recommended treatment of any dental disease, defect or injury.

2.7 "Service Report" means a claim form showing the information about the employee, the eligible person receiving services and the services performed by the Dentist.

Article 3 PARTICIPATION

3.1 Eligibility. You are eligible to participate in the Plan on the first day of the month following 30 days of service if you regularly work 30 hours or more per week and are considered a full-time employee.

a) Also eligible for coverage is an eligible member's spouse or domestic partner. A child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member or an enrolled spouse or domestic partner:

- i. A natural child
- II. Legally adopted or placed for adoption (this is, you assume a legal obligation to provide full or partial support and intend to adopt the child).

- iii. A child for whom you have legal guardianship
- iv. A stepchild
- v. A foster child
- vi. A natural child that a court orders to be covered.

b) A child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

c) In addition, a child must be one of the following:

- Under age 26
- An unmarried full-time student enrolled in an accredited educational institution. Full-time student status continues during:
 - i. Regularly scheduled school vacations; and
 - ii. Medically necessary leaves of absence until the earlier of one year from the first day of leave or the date coverage would otherwise end.
- An unmarried child who is totally and permanently disabled, either physically or mentally. The disability must have existed before the child turned age 26 or while the child was a full-time student. The child must have had creditable coverage without a break of 63 days or more since the child turned age 26 or since becoming a full-time student.

3.2 Types of Coverage. There are different categories of coverage you may hold under this Plan:

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

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

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

- the participant's name and last known mailing address, if any;

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

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

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

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

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

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

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

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

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

- The name of the claims administrator(s) for the respective benefit plan(s).
- The dependent child's effective date(s) of coverage.
- The name of the benefit plan(s) and any other relevant identifying information (e.g. an account number).
- The type of benefit plan(s) under which the dependent child has been enrolled, including whether dental, vision, office visits, and prescription drugs are covered services; and
- A brief description of the applicable deductibles, coinsurance, waiting periods for preexisting conditions, and other significant terms or conditions materially affecting the benefits or coverage.

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

If we decide that the order is not a Qualified Medical Child Support Order, each dependent child specified in the order is entitled to submit a written appeal to us. Within 30 days of receiving the appeal, we will respond in writing.

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

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

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

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

3.4 When Benefits Begin. Your rights to receive benefits under this Plan begin on your effective date. If you have just started a new job, check with the Plan Administrator to find out your effective date.

Please note: Before you receive benefits under this Plan, you have agreed on the application for benefits (or in documents kept by Employee Benefit Systems or us) to release any necessary information requested about you so Employee Benefit Systems can process claims for benefits. You must allow any dentist or his or her employee to give Employee Benefit Systems information about a treatment or condition. If Employee

Benefit Systems does not receive the information requested, or if you withhold information in your application, your benefits may be denied.

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

3.5 When Benefits End. Your eligibility for benefits under this Plan will terminate on the last day of the month for any of these reasons:

- You become ineligible for coverage under this Plan. See Eligibility earlier in this section.
- You become unemployed.
- We decide to discontinue coverage or replace this coverage.
- Employee Benefit Systems decides to terminate this Plan by giving written notice to us 90 days prior to termination.

Your coverage will end if any of the following reasons occurs:

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

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

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

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

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

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

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

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

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

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

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

If you lose your coverage, contact your Plan Administrator for COBRA rights.

3.8 Length of Coverage under COBRA. Continuation coverage ends at the earliest of one of these events:

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

3.9 Coverage Changes/Events Changing Coverage. Certain events may require you to change who is covered by this Plan. These events include:

- Active Duty in the Military of a dependent child or spouse.
- Appointment as a Legal Guardian of a child.
- Birth or Adoption of a child.

- Care of a Foster Child (when placed in your home by an approved agency).
- Dependent child ceases to be a “dependent” under the Plan
- Death.
- Divorce, Annulment, or Legal Separation of a participant.
- Exhaustion of COBRA Coverage.
- Marriage.
- Spouse or Dependent Loses Eligibility for Qualifying Dental Coverage or we cease contributions to qualifying dental coverage. In this case, your spouse and any eligible, dependent children previously covered under the prior qualifying dental coverage are eligible for coverage under this Plan.

3.10 Notification of Change. You must notify us within 31 days of the date of the event that changes the status of your eligibility except birth or adoption of a child. We must be notified within 60 days of the date of the event that changes your eligibility for births or adoptions. If we are not notified within 31 days of an event (except birth or adoption of a child which is 60 days), the person(s) affected may lose important coverage.

3.11 Coverage Termination/Effects of Termination. If your coverage is terminated for fraud, misrepresentation, or the concealment of material facts:

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

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

3.12 Right to Recover Payments/Payment in Error. If for any reason payments made under this Plan are in error, Employee Benefit Systems may recover the amount paid.

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

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

You and your family agree to all of the following:

- You will notify Employee Benefit Systems of any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that Employee Benefit Systems determines they will need to enforce the Plan’s rights.
- You will do nothing to prejudice the Plan’s rights and interests.

- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting Employee Benefit Systems' written permission.
- You must reimburse Employee Benefit Systems to the extent of benefit payments made under this Plan if payment is received from the other party or parties.
- You must notify Employee Benefit Systems if you or your beneficiaries have the potential right to receive payment from someone else.
- You must cooperate with Employee Benefit Systems to ensure that Employee Benefit Systems' rights to subrogation are protected.

3.14 Other Information/Notice. You may send any notice to the Plan at the following address:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

Any notice from Employee Benefit Systems to you is acceptable when sent to your address as it appears on Employee Benefit Systems' records or the address of the Hope Haven Area Development Center Corporation.

You may contact your Claims Administrator at the following address:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

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

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

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

3.18 Information if You or a Member of Your Family is Enrolled in Medicaid.
Assignment of Rights: This Plan will provide payment of benefits for covered services to a participant, beneficiary, or any other person who has been legally assigned the right to

receive such benefits under requirements established pursuant to Title XIX if the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid: Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this Plan, nor will it affect determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties: If payment has been made by Medicaid and Employee Benefit Systems has a legal obligation to provide benefits for those services, then Employee Benefit Systems will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Article 4 IMPORTANT INFORMATION

4.1 Questions Employee Benefit Systems Asks When You Receive Dental Care.

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

Is the Procedure Dentally Necessary? All of the following must be true for a procedure to be considered dentally necessary:

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

Is the Procedure Dentally Appropriate? All of the following must be true for a procedure to be considered dentally appropriate:

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

Is the Procedure Subject to Benefit Limitations? Benefit limitations refer to amounts that are your liability based on the terms of the Plan. Examples of benefit limitations include all of the following:

- Amounts for procedures that are not dentally necessary or dentally appropriate.

- Amounts for procedures that are not covered by this Summary Plan Description. See “Services Not Covered” in Article 1.
- Amounts for procedures that have limitations associated with them. For example, teeth cleaning is covered twice per benefit period. More frequent teeth cleaning is not a benefit even if your dentist verifies that it is dentally necessary and dentally appropriate. See “Benefits” in Article 1 for a description of covered procedures and limitations associated with certain procedures.
- Amounts for procedures that have reached contract benefit maximums. See the “Summary of Benefits and Payment” chart in Article 1.

4.2 Payment Policy. Employee Benefit Systems’ policy is to send payment for treatment after it is completed – not before. For example, Employee Benefit Systems will send payment for:

- A crown when it is sealed
- A fixed or removable prosthesis when it is inserted
- A root canal when it is filled

4.3 Understanding Payment Vocabulary.

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

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

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

Covered Charge: The covered charge is the amount a dentist bills for a dental procedure that is a benefit of your Plan.

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

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

For services billed by dentists outside of Iowa, the maximum allowable fee is based on information from that state’s plans.

4.4 Understanding Amounts You Pay to Share Costs.

Deductible: A deductible is the fixed dollar amount you pay for covered services in a benefit period before benefits are available under this Plan. This amount is shown on the “Summary of Benefits and Payment” chart in Article 1. Please note: the family deductible is reached from deductible amounts paid on behalf of any combination of members.

Coinsurance: Coinsurance is the amount, calculated using a fixed percentage, you pay each time you receive certain covered services. These amounts are shown on the “Summary of Benefits and Payment” section in Article 1 of this Summary Plan Description.

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

Benefit Period Maximum: The benefit period maximum is the maximum benefit each member is eligible to receive for certain covered services in a benefit period. The benefit period maximum is reached from claims settled under this Summary Plan Description in a benefit period. This amount is shown on the “Summary of Benefits and Payment” section in Article 1 of this Summary Plan Description.

4.5 Help When You Have Questions. If you have any questions after reading this Summary Plan Description, please call Employee Benefit Systems. (319) 752-3200.

4.6 Alternate Benefit Provision. When more than one dental service could provide suitable treatment based on common dental standards, the Claims Review Office will determine the dental service on which payment will be based and the expenses that will be included as covered expenses.

4.7 Maximum Benefit Provision. The total amount payable for all expenses incurred for a person in a calendar year will not be more than the maximum benefit shown in the schedule.

4.8 Missing Teeth Limit. No payment will be made for the first replacement of teeth that are lost and for which medical or dental care, treatment, services, medication, diagnosis or consultation was received or recommended within the 6 month period immediately preceding the enrollment date in the Plan. After a person has been enrolled for 12 months (18 months for Late Enrollees) this limit will no longer apply.

A pre-existing condition exclusion period may be decreased by the amount of creditable coverage. The exclusion period is reduced by one day for each day a covered person was under one or more types of creditable coverage. Only one day of creditable coverage will be counted regardless whether the individual is covered under more than

one plan on that day. Days of creditable coverage that occur before a significant break in coverage are not counted.

4.9 Establishing Creditable Coverage. Creditable coverage may be demonstrated in two ways. The first way is by a certificate, which applicants should have received at the time their other coverage ceased, individuals may also request, and receive, a certification of creditable coverage from their prior plan. The prior plan is required to provide the certificate by the earliest date that the plan or health insurance issuer, acting in a reasonable and prompt fashion, can provide the certificate, provided the request is made within 24 months of the date prior coverage ended. If necessary, this Plan will assist individuals in obtaining such certification.

To demonstrate creditable coverage without a certification, individuals must attest in writing to the existence of creditable coverage, supply relevant supporting evidence of such coverage and cooperate with this Plan's efforts to verify the existence and duration of the coverage.

For the purposes of this section, creditable coverage means coverage of individuals under any of the following, excluding excepted benefits, as defined in HIPAA (Health Insurance Portability and Accountability Act).

1. Group Health Plan
2. Health Insurance
3. Medicare
4. Medicaid
5. TRICARE
6. State Risk Pool
7. Federal Employee Health Plan
8. Public Health Plan
9. Peace Corps Health Plan
10. Health care plans run by the Indian Health Service
11. State Children's Health Insurance program (SCHIP)

Article 5 NOTIFICATION PROGRAM

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

You should notify Employee Benefit Systems before you receive treatment for the following:

- Gum and Bone Diseases

Employee Benefit Systems' review is based on the treatment plan submitted by your dentist.

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

When to Submit a Treatment Plan: A complete treatment plan includes the plan of treatment and x-rays. Please send the x-rays within 15 working days of receipt of the proposed treatment plan.

Where to Send a Treatment Plan: Submit the proposed treatment plan, along with x-rays and supporting information to:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

5.3 The Treatment Plan Review. Once Employee Benefit Systems receives the treatment plan and proper documentation, Employee Benefit Systems will let you and your dentist know if the treatment plan is approved within 15 working days. Employee Benefit Systems will take one of the following three actions when they receive your treatment plan:

- Accept it as submitted
- Recommend an alternative benefit. Employee Benefit Systems may ask you to receive an independent diagnosis from another dentist.
- Deny the treatment plan because:
 - the procedure is not a benefit of this Plan
 - you did not receive an independent exam after Employee Benefit Systems asked you to; or
 - the procedure is not dentally necessary and dentally appropriate

Appeal: If Employee Benefit Systems denies a treatment plan, you can request in writing, Employee Benefit Systems, to reconsider. You may be required to submit additional documentation. If necessary, Employee Benefit Systems will ask you to receive an independent diagnosis from an independent dentist of Employee Benefit Systems' choice.

Although Employee Benefit Systems may approve a treatment plan, neither Employee Benefit Systems nor this Plan are liable for the actual treatment you receive from your dentist.

Article 6 CLAIMS PROCEDURE

6.1 When to File Your Claim. After you receive services, you should file a claim only if your dentist has not filed one for you. Employee Benefit Systems may disallow payment of a claim submitted more than 365 days after the date services were rendered.

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

If you need a claim form or have any questions after reading this section, please call Employee Benefit Systems. If you must file your own claim, send it to the following address:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

6.2 Filing When You Have Other Coverage/Coordination of Benefits. You may have other insurance or coverage that provides the same or similar benefit(s) as this Plan. If so, Employee Benefit Systems will work with your other insurance company or carrier or health plan. The benefits payable under this Plan when combined with the benefits paid under your other coverage will not be more than 100 percent of either Employee Benefit Systems' payment arrangement amount or the other carrier's or health plan's payment arrangement amount.

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

- Inform your dentist by giving him or her information about your other coverage at the time you receive services. Your dentist will submit the information to Employee Benefit Systems when the claim is filed.
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. Employee Benefit Systems will contact you if any additional information is needed.

You must cooperate with Employee Benefit Systems and provide requested information about your other coverage. If Employee Benefit Systems does not receive the necessary information, your claims will be denied.

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

- The coverage without coordination of benefits pays first when both coverages are through a group sponsor such as an employer, but one coverage has coordination of benefits and one does not.
- The dental benefits of your auto coverage will pay before this coverage if the auto coverage does not have a coordination of benefits provision.

- The coverage which you have as an employee or plan member participant pays before the coverage which you have as a plan beneficiary spouse or dependent child.
- The coverage you have as the result of your active employment pays before coverage you hold as a retiree or under which you are not actively employed.
- The coverage with the earliest continuous effective date pays first when none of the above rules apply.

If none of the guidelines listed above apply to your situation, Employee Benefit Systems will use the Coordination of Benefits (COB) guidelines adopted by the Iowa Insurance Division to determine payment to you.

What you Should Know About Beneficiaries who are Dependent Children: To coordinate benefits for a dependent child the following rules apply. For a child who is:

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

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

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

Employee Benefit Systems may obtain the advice of independent dentist or require such other evidence as it deems necessary to decide your claim.

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

- The specific reasons for the denial;
- Reference to the specific provisions of the Plan on which the denial is based;
- A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary; and
- Appropriate information as to the steps to be taken if you wish to appeal the decision of Employee Benefit Systems, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

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

Your request for a review should state the reasons why you believe your claim should not have been denied. It should include any additional facts and/or documents that you believe support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) all documents, records, and other information relevant to your claim and its review. Employee Benefit Systems will review all written comments that you submit with your request.

Send your request to:

Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

Employee Benefit Systems will review your request and decide your appeal within a reasonable time not longer than 60 days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that person's subordinate. Employee Benefit Systems may secure the advice of independent dentists or others and require such evidence as it deems necessary to decide your appeal, except that any dental or other expert consulted in connection with your appeal will be independent of

your initial claim. If the decision on review affirms the initial denial of your claim, you will be given a notice of denial on review that provides the following information:

- The specific reason(s) for the denial;
- The specific provisions of the Plan on which the decision is based;
- A statement of your right to review (on request and at no charge) relevant documents and other information;
- If Employee Benefit Systems relied on an “internal rule, guideline, protocol, or other similar criterion” in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request; and
- A statement of your right to bring suit under ERISA § 502(a).

Article 7 PLAN ADMINISTRATION

7.1 Plan Administration. The administration of the Plan is under the supervision of the Plan Administrator, Hope Haven Area Development Center Corporation. The Human Resources Manager of Hope Haven Area Development Center Corporation is the person who acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to ensure that the terms of the Plan are carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Company bears all costs of administering the Plan and for paying all claims.

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

Article 8 GENERAL PROVISIONS

8.1 Your ERISA Rights. Your rights concerning your coverage may be protected by the Employee Retirement Income Security Act of 1974 (“ERISA”). Any employee benefit plan established or maintained by an employer or by an employee organization or both is subject to this federal law unless the benefit plan is a governmental or church plan as defined in ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) provides that you will be entitled to:

- Examine certain plan documents and copies of documents (such as annual reports filed by the Plan with the United States Department of Labor. You may examine these documents at the plan administrator's office or at specified locations. You will not be charged to examine these documents.
- Obtain copies of certain plan documents from the plan administrator upon written request. The plan administrator may request a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report if we have 100 or more participants in your Plan. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

8.2 The Responsibility of Your Employee Benefit Plan. In addition to creating rights for you and other participants, ERISA imposes duties upon the people responsible for the operation of your employee benefit plan. The people responsible are called fiduciaries of the plan. Fiduciaries have a duty to operate your employee benefit plan prudently and in the interest of you and your family members. No one, including us, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a covered benefit or exercising your rights under ERISA. If your claim for a covered benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to request a review and reconsideration of your claim.

8.3 Steps You Can Take to Enforce Your Rights. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request the plan document from the plan administrator and do not receive it within 30 days, a federal court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the document, unless the document was not sent because of matters reasonably 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. 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.

8.4 Who to Contact When You Have Questions. If you have any questions about your plan, you should contact the plan administrator, i.e. your employer or group sponsor. If you have questions about this statement or about your rights under ERISA or HIPAA, you should contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security

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

GENERAL INFORMATION

Self Funded Dental Plan

Sponsored by Hope Haven Area Development Center Corporation

Name and Address of Employer(s): Hope Haven Area Development Center Corporation

Plan Name: Hope Haven Area Development Center Corporation Self Funded Dental Plan

Type of Plan: A group health plan (a type of welfare benefits plan that is subject to the provisions of ERISA)

Plan Year: January 1 – December 31

Plan Number: 49530

Original Effective Date: November 1, 2006. The Plan has been amended several times since its original effective date.

Plan Sponsor: Hope Haven Area Development Center Corporation
1307 Broadway
West Burlington, IA 52655

Employer Identification Number: 42-1000580

Plan Administrator: Hope Haven Area Development Center Corporation
1307 Broadway
West Burlington, IA 52655
(319)754-4689
Attn: Human Resources Specialist

Claims Administrator: Employee Benefit Systems
214 North Main Street
P.O. Box 1053
Burlington, IA 52601

Named Fiduciary:

Hope Haven Area Development
Center Corporation
1307 Broadway
West Burlington, IA 52655
(319)754-4689

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

Source of Contributions:

Contributions for the Plan are made in part by Hope Haven Area Development Center Corporation and in part by employees' pre-tax payroll deductions.

Agent for Service of Legal Process:

President
Hope Haven Area Development
Center Corporation
1307 Broadway
West Burlington, IA 52655
(319)754-4689

Legal Plan Document and Disclaimer: This Plan Document summarizes the principal features of the Plan in a general manner.

BY THIS AGREEMENT, Hope Haven Area Development Center Corporation Self Funded Dental Plan is hereby adopted as shown.

Executed this 21 day of January, 2011 on behalf of the Employer.

By: 

Title: Director of Fiscal Management