Summary Plan Description and Plan Document

This Summary Plan Description explains in detail how the Plan works. However, if you have any questions concerning your benefits, ask your employer or benefits representative for more details.

Some employers are subject to ERISA. Under ERISA, the information contained in this document is provided to comply with ERISA, which is the Employee Retirement Income Security Act of 1974, As Amended. If your employer is not subject to ERISA, this document provides valuable information about your plan for informational purposes only.

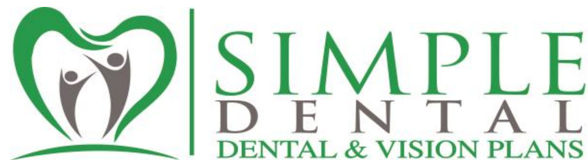
Employer, Plan Sponsor, Plan Administrator, and agent in the event of legal action involving the Plan: CITY OF ST. PETER
Address: 227 South Front St. Saint Peter, MN 56082
Name of Plan: Dental
Group Number: S171
Claims Processor: Covenant Administrators, LLC., 90 Degree Benefits, dba “Simple” (Simple), 2810 Premiere Parkway, Suite 400, Duluth, GA 30097
Dependent Age Limit: 26 (coverage ends on birthday)
Type of Plan: Self-funded Dental Plans
Plan Year: January 1 thru December 31
Coverage begins: 1st of month following the date of employment

Benefit Amounts Paid by the Plan:
The Plan Year in which the treatment is provided is the year used to determine the reimbursement.

*The **Dental Plan** will pay for benefits for each covered person as follows:*
100% of the first $250 of expenses, then
60% of the remaining dental expenses
Maximum Plan Year Benefit of $1,250 per person.
Orthodontics is not covered.
80th Percentile Usual, Customary and Reasonable Reimbursement Schedule

The Plan is a self-funded, uninsured benefit plan that reimburses eligible employees and their eligible dependents for covered dental expenses.

- The Claims Processor processes claim payments on the behalf of the Employer but provides no funds and no insurance to pay any claims.
- Claims can only be paid if funds are available in the claim fund bank account. If submitted claims for all covered individuals are higher than anticipated, it is possible that claim processing will be delayed.
- The Plan is available to the employees of Employer and its affiliates that participate in the Plan.
- The Plan does not involve an insurance company.
- This Plan is not regulated by any government, insurance department or regulatory because it is not an insured plan—it is a reimbursement plan.



- If you elect to participate in the Plan, your pay will be reduced so that your premium is paid on a pre-tax basis. You can have the premium paid on an after-tax basis if you state this in writing to the Plan Administrator.
- You may elect to cover only yourself or you may elect to cover yourself and your eligible dependents. You cannot elect coverage for your dependents alone.
- As you incur expenses—as you "have a claim", you may submit these claims for reimbursement to the Claims Processor.
- If your expenses are eligible for reimbursement under the terms of the Plan, you will receive a check for all or a portion of the reimbursable expenses, according to the plan benefits. The Employer reserves the right to amend or terminate this Plan at any time. Nothing in this Summary Plan Description shall imply that benefits are vested or cannot be changed. The Employer can also change the benefits or contributions under the Plan or any other aspect of the Plan at any time and for any reason. The changes can apply to all covered persons. These amendments will normally not affect expenses incurred prior to the date of enactment of the amendments.

Reimbursement Schedule:
Simple processes all claim on behalf of the employer based upon a Reimbursement Schedule. Any benefit amount funded by the employer will be calculated based on this schedule. Charges by any dentist over what the employer has committed to fund will be the employee's responsibility. The financial obligation will be calculated and communicated each time a claim is submitted for payment and will appear on the Explanation of benefits (EOB) form.

Persons Eligible to Receive Coverage:

Employees:
- All full-time employees who have met the required waiting period, and their eligible dependents, may participate in the Plan.

Dependents:
- Eligible dependents include your spouse and unmarried children less than 26 years of age.

Handicapped children:
An unmarried child with a mental or physical handicap or developmental disability, who can't support himself/herself may stay eligible for dependent coverage beyond the Plan's age limit if:
a) The condition started before he/she reached this Plan's age limit;
b) He/she became covered by this Plan before he/she reached the age limit and stayed continuously covered until he/she reached such limit; and
c) He/she depends on you for most of his/her support and maintenance. To do this, it is the employee's responsibility to send written proof that the child is handicapped and depends on you for most of his/her support and maintenance within 31 days from the date the child reaches the age limit.

The employer may be asked for periodic proof that the child's condition continues. The child's coverage ends when yours does.

Coverage for you and your dependents/family:
You can elect one of coverage options made available by the Employer.

Special Rules for a Divorce:

- If you are divorced or separated from your spouse, you may be required under the terms of a "Qualified Medical Child Support Order" to provide coverage under the Plan to any of your children named in such order.
- A Qualified Medical Child Support Order (“QMCSO”) is an order satisfying the requirements of ERISA and requiring a health plan to recognize the child of a parent-employee as a plan participant.
- If the Plan Administrator receives a QMCSO for an employee who is not presently enrolled in the Plan, then the employee will need to be enrolled in the plan and the child(ren) will be added as dependents.

Cost of Coverage:

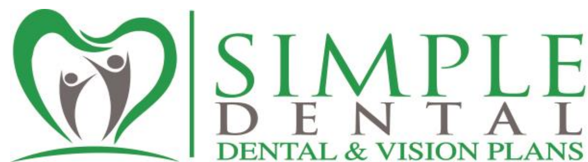
- You must pay the amounts requested by the Employer, if any, for you or your dependents to be covered.
- You will be told the exact amount at the time of enrollment.
- The Plan is self-funded, meaning that no insurance protection is available. If claims are higher than projected, the Plan Administrator may have to increase the costs that you pay for this Plan, at any time, and without prior notice.

Enrolling for Coverage:

- Prior to the first day of each Plan Year, the Company will provide an annual enrollment period during which you may elect coverage under the Plan.
- If you already have coverage, you can change the type of coverage (for example, from individual to family coverage). The coverage that you elect during the annual enrollment period will become effective on the first day of your plan year following the annual enrollment period.
- If you do not make changes during the annual enrollment period, you will continue with same election you made for the prior year, although benefits and costs may change.
- If you become employed during the Plan Year and you elect coverage during a period other than the open enrollment period, your coverage will be effective on the date specified by your Employer.
- In the event that an employee is also a dependent of another covered employee, the employee can elect to be covered only once—either as the employee or as the dependent.

Changing the coverage election or change of family status:

- Your election to receive coverage under the Plan will remain in effect for the Plan Year.
- If you are a new employee and elect coverage during a period other than the open enrollment period, your initial election will remain in effect from the date your election became effective until the end of the Plan Year.
- If you do not complete a new election form for coverage during the next annual enrollment period, your election automatically will remain in effect for the next Plan Year.



- You may change or revoke your election during the Plan Year only if you experience a "change in family status", and the change in coverage is on account of and consistent with the change in family status.

Examples of changes in family status include:

1. Your marriage, divorce or legal separation;
2. The birth or adoption of a child;
3. The death of a dependent;
4. A dependent that either becomes eligible for coverage or is no longer eligible;
5. A change in your spouse's employment;
6. The receipt of a qualified medical child support order;
7. A "special enrollment period," as required under the Internal Revenue Code; or
8. Any other event deemed a change in family status by the Plan Administrator, in accordance with applicable law.

Expenses Covered:

- You will be reimbursed for all properly submitted covered expenses incurred by you or your covered dependents while you are covered under the Plan, except for those expenses discussed below that are not covered under the terms of the Plan.
- Covered expenses include treatment by any licensed provider.

Expenses Not Covered:

- Expenses incurred for injuries or conditions, which are payable through workers' compensation;
- Expenses incurred for services, which are covered by a governmental agency;
- Expenses incurred for cosmetic procedures to include, but not necessarily limited to, cosmetic veneers and bleaching. The Plan Administrator determines what claims are considered cosmetic, based on industry consensus.
- Orthodontia, including related charges.
- Charges that exceed the Reimbursement Schedule.

Claim Filing:

- When you or a covered dependent incur expenses, submit a claim form signed by the provider that describes the dates of service, the type of treatment and the charge. Properly completed claim forms should be sent directly to the Claims Processor by Fax, Email or Direct Mail. In the event that the provider cannot submit a claim form, submit receipts yourself for reimbursement. Each receipt must be mailed one-receipt per envelope, fax or email transmittal. The Claim Processor is not responsible for sorting and organizing receipts.
- The Claim Processor reserves the right to confirm expenses or request the original receipt prior to reimbursing any claim.
- Failure to present the original claim as request and when requested may result in a total denial of any claim.
- A fraudulent claim is grounds for termination of benefits and criminal prosecution determined within the sole discretion of the Plan Administrator.

- Claim payment will be made within 30 days by the Claim Processor. If the claim cannot be paid in 30 days, the Claim Processor will provide notification of why the claim cannot be paid.
- All claims for expenses must be submitted no later than 90 days after date the dental care or treatment is incurred.

Coordination of Benefits (COB)

Coordination of Benefits ("COB") applies when a Covered Person has dental coverage under more than one benefit plan. "Other Plan" is defined below. The intent is that not more than 100% of the Allowable Expense is paid from the total benefits available between all benefit plans. Under this provision, the benefits of this Dental Plan may be reduced so that they and the benefits payable under the Other Plans do not total more than those Allowable Expenses.

- If this COB provision applies, the order of benefit determination rules (set forth below) will be applied to determine benefits under this Dental Plan. Those rules determine whether the benefits of this Dental Plan are determined before or after those of another Plan.
- Primary Plan/Secondary Plan. The order of benefit determination rules state whether this Dental Plan is a Primary Plan or Secondary Plan to another Plan covering the Covered Person.
  - (i) When this Dental Plan is a Primary Plan, its benefits shall not be reduced, and are determined before those of the Other Plan and without considering the Other Plan's benefits.
  - (ii) When this Dental 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.
- Allowable Expense means a necessary, reasonable, and customary item of expense for healthcare, when the item of expense is covered at least in part by one or more Other Plans covering the Covered Person for whom the claim is made.
- Other Plan means any of the following which provide benefits or services for, or because of, dental care or treatment:
  - (i) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, and individual practice coverage. It also includes coverage other than school accident-type 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 Act, as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance or other non-governmental program.
- Order of Benefit Determination Rules. This Dental Plan determines its order of benefits using the first of the following rules which applies:
  - (i) Non-Dependent/Dependent. The benefits of the plan which covers the Covered Person as an employee or dependent (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.
  - (ii) Dependent Child/Parents Not Separated or Divorced. Except as stated in

subparagraph (3), when this Dental Plan and the Other Plan cover the same child as a dependent of different persons, called "parents":

1) 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
2) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
3) However, if the Other Plan does not have the birthday rule described above 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 will determine the order of benefits.

(iii) 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:

1) First, the plan of the parent with custody of the child.
2) Then, the plan of the spouse of the parent with custody of the child.
3) Finally, the plan of the parent not having custody of the child.
4) However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the 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.

(iv) Active/Inactive Employee. The benefits of a plan that 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.

(v) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered the Covered Person longer are determined before those of the plan that covered that Covered Person for the shorter time.

Recourse for Denied Claims:

- If a claim is denied (all or in part), you will be informed of the reason(s) for denial, and you may initiate a review of the claim by contacting the Plan Administrator for further instructions.
- Under the review procedure, you or your duly authorized representative have the right to: (a) request the review by making written application to the Plan Administrator, no later than 60 days after the claim denial, (b) review pertinent Plan documents, and (c) submit issues and comments in writing in support of the claim.

- You will be notified in writing of the results of the claim review and the reason for any denial no later than 60 days following receipt of the properly completed request for review, unless it is necessary to seek additional information, in which case the determination will be made within 20 days of receiving the additional information.
- Any requests for review not responded to within this period shall be deemed denied.

Termination of Coverage:
Coverage for you, as well as that of your dependents, ends on the last day of the month in which your employment ends, subject to your right to elect COBRA coverage:

- The date this Plan is terminated by the Employer or by Simple;
- The date this plan is amended to exclude you or your dependents from the class of employees or dependents, as applicable, eligible for coverage;
- The date you are no longer in an eligible class of employees or, with respect to a dependent's coverage, the date the dependent is no longer an eligible dependent;
- The last day of the month in which your employment ends;
- The date of your death; or
- The date you withdraw from the Plan.
- If you take a leave of absence pursuant to the Family and Medical Leave Act, (“FMLA”), your elected coverage will be continued by the Company for the authorized period of leave. You will have to pay the premium for your coverage while on leave.

Your Rights Under COBRA:
You have rights under COBRA law, which are addressed separated under the IRS rules for COBRA compliance. The Claims Processor provides no services related to COBRA other than acknowledging that you are a COBRA participant in such situations as this may occur. Check with your Employer to learn of your full rights under COBRA.

Who Is Eligible for COBRA
You and your dependents (“Qualified Beneficiaries”) are eligible for COBRA continuation coverage if you and your dependents are actually covered under the Plan at the time of your “qualifying event,” as described below. In addition, a child born to or adopted by an individual covered under COBRA is also considered a Qualified Beneficiary.

In addition to the above events, your spouse and dependent children are eligible for COBRA continuation coverage if they are actually covered under the Plan at the time of any of the following qualifying events:

- Your divorce or legal separation;
- Your death; or
- Your becoming entitled to benefits under Medicare.

In addition to the above events, your dependent children will be eligible for COBRA continuation coverage if they are actually covered under the Plan at the time, they lose coverage under the Plan due to loss of dependent status.

What Notice Do I Have To Give For COBRA To Take Effect?

The Plan Administrator has no way of knowing when you are divorced or when a dependent child loses eligibility. Therefore, it is your responsibility and the responsibility of affected dependents to notify the Plan Administrator within 60 days of a divorce, legal separation of loss of a child's dependent status under the Plan. If this notice is not received within 60 days, the dependent will permanently lose eligibility for COBRA continuation coverage.

How Long Does Cobra Coverage Last?

COBRA continuation coverage may extend for 18 months in the case of your termination of employment or reduction of hours and otherwise for 36 months, provided that a covered dependent lost coverage under the Plan as a result of the qualifying event. If coverage under the Plan continues beyond the occurrence of a qualifying even, the 18- or 36-month period will not begin until loss of coverage. The 18-month period may be extended if a second qualifying event causing loss of coverage (for example, death, divorce or legal separation) occurs during that period. Coverage will never last more than 36 months from the date of the original qualifying event (i.e., the date you terminated employment with a participating company, or your hours were reduced). However, if you (the covered employee) separate from service or reduce your hours less than 18 months after the date you became entitled to Medicare, then the coverage for your dependents may be extended to a maximum of 35 months from the date you became entitled to benefits under Medicare.

What Are My Rights Under COBRA If I Am Disabled?

Qualified Beneficiaries deemed disabled for Social Security purposes (and their covered family members) can extend coverage up to 29 months if:

- The Qualified Beneficiary is determined, under the Social Security Act, to have been disabled without 60 days of the date COBRA coverage commenced for the Qualified Beneficiary;
- The determination of disability is made before the end of the initial 18-month continuation period; and
- A copy of the disability award is provided to the Plan Administrator within 60 days of the date of determination and before the end of the 18-month continuation period.

In the case of COBRA continuation coverage that is extended beyond the 18 month continuation period due to a Qualified Beneficiary's disability, COBRA continuation coverage will terminate on the first day of the month that begins more than 30 days after it is determined that the Qualified Beneficiary is no longer disabled, unless coverage is terminated earlier for any of the reasons described below for the termination of COBRA coverage.

Can COBRA Coverage Terminate Earlier Than Described Above?

Yes, although COBRA will generally continue for either the 18, 29, or 36 month period described above, it can be terminated earlier for any of the following reasons.

- The Qualified Beneficiary fails to pay the premium in a timely manner, defined initially as within 45 days of the date of the election and thereafter within 30 days of each due date;

- The Qualified Beneficiary becomes covered under another group plan (unless the Qualified Beneficiary is subject to pre-existing condition exclusions under that plan);
- The Qualified Beneficiary becomes entitled to Medicare benefits. However, your covered dependents may still continue their coverage if you become eligible for Medicare; or
- The Plan is terminated in its entirety and neither the Company nor its affiliates maintain any type of group plan.

If COBRA coverage terminates, it cannot be reinstated.

How Do I Elect COBRA Coverage?

Qualified Beneficiaries will be notified in writing of their eligibility for COBRA continuation coverage and of the election procedures. In order to obtain COBRA continuation coverage, Qualified Beneficiaries must follow all instructions sent with the notice of eligibility. Generally, Qualified Beneficiaries will have 60 days from the date notice to elect COBRA coverage. During this 60-day election period, the Qualified Beneficiaries must decide if they intend to continue their coverage by agreeing to pay the premiums on a monthly basis.

How Do I Pay for COBRA Coverage?

Payments for COBRA continuation coverage are payable monthly to the Employer and are due by the first of each month. COBRA continuation coverage will terminate if payments (other than the first payment) have not been received within 30 days of the first of each month. The first payment for COBRA continuation coverage is due within 45 days after you make your election to receive COBRA continuation coverage and the election is received by the Employer. If the payment is not made within the 45 days for the first payment, COBRA continuation coverage will terminate. The Employer is not required to send you payment reminders or overdue notices.

Plan Funding:
Company and employee contributions cover the projected cost of the Plan. In the event the contributions are not able to cover the actual claims, the Plan may receive additional funds from the Employer and/or Employees, or the Plan may be terminated. Company contributions and any employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All employee contributions to the Plan shall be withheld from the employee’s paycheck on a pre-tax basis unless the employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis.

ERISA RIGHTS:
Not all plans are subject to ERISAS. Certain government and non-profit entities, among other businesses are not subject to ERISA. If your employer is subject to ERISA, as a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement

Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan and an 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 participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer 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. If your claim for a welfare 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 have the plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 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 the 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.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.