



Dental Expense Coverage

Effective June 1, 2007

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SUMMARY PLAN DESCRIPTION

This booklet contains a general description of your benefits and is written to help you understand them. The details of your coverage are limited to the terms and conditions specified in the Plan. You may examine the Plan or obtain copies of it at any time. It is on file with Drake University.

This Plan was established for the exclusive benefit of the employees of Drake University with the intention it will continue indefinitely. However, Drake University reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the President of Drake University or his/her designee, and will be binding. If this Plan is terminated, you may not receive benefits for claims incurred on or after the effective date of termination.

INTRODUCTION

This Plan is designed to cover your various dental care expenses. This is a self-funded Plan of benefits which provides each covered person with a calendar year maximum of \$1,000 coverage for dental care needs.

It is important you understand this Plan in order to use it effectively. You are encouraged to take the time to read this booklet to gain a basic understanding of your benefits. The "Benefit Summary" which follows provides a brief review of the allowable benefits. The "Description of Dental Benefits" section provides greater detail regarding your benefits.

If you have any questions about this Plan of benefits, please contact First Administrators, Inc. Correspondence can be mailed to:

First Administrators, Inc.
PO Box 9900
Sioux City, IA 51102-0479

or

you may call:

Nationwide.....1-800-206-0827

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless you have been notified, in writing, that another entity is your Plan Sponsor. Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator cannot disclose protected health information to your Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of your Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator will disclose protected health information to your Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by your Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by your Plan to account for disclosures in accordance with 45 CFR § 164.528;
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64;

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not

feasible to return or destroy all of the protected health information, your Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of your Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance

to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

The sponsor will ensure that these provisions for adequate separation between the sponsor and the Plan are supported by reasonable and appropriate security measures.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

**DRAKE UNIVERSITY
DENTAL BENEFIT PLAN
BENEFIT SUMMARY**

Group # 92400

Effective Date: June 1, 2007

DENTAL BENEFITS	PLAN PAYS	YOU PAY	GENERAL PLAN LIMITS	PAGE
Dental Deductible to be paid before the following benefits are paid: - Per Individual/CAL YR	\$0	\$50		19
Preventive Dental Benefits - Routine oral exams - Full mouth x-rays - Bitewing x-rays - Other x-rays as necessary - Teeth Cleaning - Non-emergency exams - Emergency palliative treatment - Space maintainers - Sealants - Fluoride application - Biopsy of oral cavity	100%	0%	Calendar year deductible waived. Limited to twice per calendar year. Limited to once every thirty-six months. Limited to twice per calendar year. Limited to twice per calendar year. Limited to dependent children under age 14. Limited to dependent children under age 14, and to once every four years per quadrant. Limited to dependent children and to one application per 12-month period.	19
Basic Dental Benefits - Restorations - Repair of crowns, bridges, dentures - Re-cementing of space maintainers - Simple tooth extractions and removal of impacted teeth - Periodontic services - Endodontic treatment (root canal therapy) - Oral surgery, including anesthesia - Denture relining	80%	20%	A six-month waiting period may apply. See the "Description of Dental Benefits" section. Removal of impacted teeth on a medically necessary basis is covered under the medical plan. Includes periodontic prophylaxis. Surgical procedures are limited to one service per quadrant per 12-month period. Periodontic appliances limited to one every three years. Scaling and root planing limited to once every six months. Only covered if done more than one year after the initial installation and then not more than once each two-year period.	19
Major Dental Benefits - Gold foil restorations - Inlays and onlays as restorations - Fixed or removable bridges - Crowns - Pontics - Dentures	50%	50%	A twelve-month waiting period may apply. See the "Description of Dental Benefits" section. Only covered after enrolled in the Plan for 24 months. Only covered after enrolled in the Plan for 24 months.	20
Calendar Year Maximum Benefit	\$1,000			19

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for dental coverage if he/she is a regular full-time employee at least nine months per calendar year and is scheduled to work thirty-two (32) or more hours each week. If the employee ceases to work, or is no longer scheduled to work thirty-two (32) or more hours a week, he/she ceases to be a covered employee under this Plan. An employee is also eligible if he/she is a participant in an approved transitional or other leave program pursuant to a formal written plan of Drake University. A finding by a government or other agency that an individual providing services to Drake University should have been classified as an employee by the employer is not sufficient to establish eligibility under this Plan.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first day of the month following your hire date providing you enroll for coverage within thirty-one (31) days following the completion of the waiting period.

If you are eligible for coverage, but are not actively at work on the day your coverage is scheduled to begin because of any reason other than a medical condition or disability, this Plan will become effective the day you return to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason you are not working is because the day is not a regularly scheduled work day.

If you do not apply to become a covered employee by completing an enrollment form or application within the thirty-one (31) day period following the date you are eligible, you will only be able to enroll during the open enrollment period. For further details, see the section on the **Open Enrollment Period**.

In some cases, there may be "special" circumstances that will allow you to enroll for coverage without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which your active employment with Drake University is terminated;
- (b) the last day of the month you cease to be in a class of employees eligible for coverage;
- (c) the end of the period for which you have made contributions if you fail to make the next required contribution;
- (d) the date this Plan is terminated with respect to Drake University, and there is no successor plan;
- (e) the last day of the month you voluntarily elect to be terminated from this Plan, subject to the pre-tax premium rules as outlined in this booklet.

If you cease active employment due to layoff or an authorized leave of absence participation may be continued pursuant to rules adopted by Drake University and applied on a uniform basis to all covered employees similarly situated. Also, participation may be continued if you are on an approved disability leave of absence pursuant to rules adopted by Drake University and applied on a uniform basis to all covered employees similarly situated.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though these services are furnished as a result of a condition that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee may choose to cover his/her dependents (as defined) under this Plan.

Coverage is provided for a domestic partner who satisfies the following criteria:

- is at least eighteen (18) years of age and of the same gender as the employee;
- has executed a notarized "relationship contract", which obligates each partner to provide support for the other and to act as each other's sole domestic partner indefinitely;

- is not able to qualify for coverage as a common law spouse;
- is not legally married or covered under any other domestic partnership arrangement with Drake University;
- is not related by blood closer than would bar marriage in the state of Iowa, and each partner is mentally competent to consent to the contract; and
- the partners have been residing together for at least six (6) continuous months immediately prior to filing the "Affidavit of Domestic Partnership".

A covered employee's unmarried dependent children may be covered until they reach the age of nineteen (19). They may be covered until the age of twenty six (26) if they are unmarried, full-time students in an accredited school.

Dependent children include natural children, adopted children (as defined), stepchildren, grandchildren or children for whom the employee has legal guardianship who are unmarried.

If both the employee and spouse are Drake University employees and they have no dependent children, each must enroll for single coverage.

If both parents are covered under this Plan as employees, a child can be covered as a dependent of only one parent. No one covered under this Plan as an employee can also be covered as a dependent.

Adopted Child

The term "dependent" found in this Plan shall include any unmarried child meeting the dependent eligibility requirements of this Plan who, prior to age eighteen (18), has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that all pre-existing condition exclusions or additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO Provision

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the limitations, restrictions, provisions and procedures as any other participant.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order, which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order the medical child support order must contain the following information:

- the name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- a reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined; and
- the period to which such order applies.

If the order is determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) If the employee already has coverage in force, the child will be covered as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- (b) If the employee is within the waiting period as specified under the section entitled "Effective Date", the child will become effective the same date the employee's coverage is effective; or

- (c) If the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material, which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within thirty-one (31) days after the individual becomes a dependent; or
- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered dependent who becomes eligible as an employee under this Plan will be considered to have satisfied his/her waiting period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period.

If the employee is absent from active work because of any reason other than his/her medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the dependent ceases to be a covered dependent as defined by this Plan;
- (b) in the event of a legal separation or divorce, coverage for the employee's spouse/domestic partner will cease at the end of the month in which the event occurred;
- (c) the last day of the month the covered dependent ceases to be in a class of dependents eligible for coverage;
- (d) the end of the period for which the employee has made contributions for a dependent's coverage if the next required contribution is not made;
- (e) the date this Plan is terminated with respect to Drake University, and there is no successor plan;
- (f) the last day of the month the covered dependent voluntarily elects to be terminated from this Plan; subject to the pre-tax premium rules as outlined in this booklet; or
- (g) August 31st if the dependent is a full-time student during the spring semester with plans to return to school for the fall semester, but fails to return to school at the end of the summer break.

If the covered dependent wishes to cancel coverage, he/she must notify Drake University prior to the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though these services are furnished as a result of a condition that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because

they were covered under another plan and to individuals acquiring a dependent. These special enrollment rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity. **All special enrollment events must be requested within thirty-one (31) days from the date of the event.**

Pre-existing condition exclusion periods for special enrollees may not exceed twelve (12) months.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to having coverage under another group health plan or due to having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;
- (c) the current employee or dependent lost other coverage pursuant to one of the following events:
 - the current employee or dependent was under COBRA and the COBRA coverage was exhausted; or
 - the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours worked);
 - the current employee or dependent moved out of an HMO service area with no other option available;
 - the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);

- the Plan is no longer offering benefits to a class of similarly situated individuals;
 - the benefit package option is no longer being offered and no substitute is available; or
 - or employer contributions were terminated; and
- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than thirty one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contribution, as described in (c) above.

For an eligible current employee or dependent who has met **each** of the conditions specified above, this Plan will be effective on the date the other coverage was lost.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee and/or spouse/domestic partner may be enrolled at the same time):

- (a) if the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse/domestic partner and/or other dependents of the current employee may also be enrolled as a dependent if the spouse/domestic partner and/or other dependent are otherwise eligible for coverage.

The dependent special enrollment period will be a period of thirty one (31) days beginning on the date of marriage, birth, adoption or placement for adoption.

If the current employee is enrolled at the time of the Special Enrollment event, the eligible dependents must be enrolled in the same Plan. Plan changes can only be made during the annual Open Enrollment Period.

If a current employee requests enrollment for a dependent during the special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, as of the date of the marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

An enrollment form or application will be required to be submitted for all newborns before coverage will begin.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of an unmarried dependent child shall not cease because of attainment of the termination age specified in this Plan, while coverage is in force and the child otherwise qualifies as a dependent, if the child:

- (a) is incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical disability; and
- (b) became so disabled prior to attainment of the termination age specified in this Plan.

You must submit to Drake University, within thirty one (31) days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

Drake University, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as Drake University may reasonably require. Drake University will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;

- (c) the date you fail to submit any required proof of the uninterrupted existence of the dependent's disability; or
- (d) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

OPEN ENROLLMENT PERIOD

Drake University will offer an annual enrollment period during which an employee may elect to participate in the Plan. Any otherwise eligible employee who has previously waived coverage may elect to participate in the Plan. All new participants added during the enrollment period are subject to deferred coverage for basic and major services. The enrollment period will be held annually during the month of April with a June effective date.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This Act requires an employer which employs fifty (50) or more employees (within a seventy-five (75) mile radius) to allow an employee who has been employed for twelve (12) months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of twelve (12) weeks of leave during any twelve (12) month period, as defined by the employer, for: the birth of a child; placement of a child with the employee for adoption or foster care; care for a spouse, child or parent of the employee if the individual has a serious health condition; or a serious health condition which prevents the employee from performing the function of his/her regular position.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as

defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of twelve (12) weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please see your employer for more information.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the twenty-four (24) month period beginning on the date on which the person's absence begins; or
- the period beginning on the date on which the covered employee's absence begins and

ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:

- for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
- for service of more than thirty (30) days but less than 181 days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;
- for service of more than 180 days, no later than ninety (90) days after the completion of the period of service; or
- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than thirty-one (31) days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage

upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

“Uniformed Services” shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant’s right to continue his/her health care coverage in the Plan is important.

Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant’s spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this SPD) applies only to the benefits

offered under the Plan and not to any other benefits offered under the Plan or by Drake University (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand the participant’s rights beyond COBRA’s requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Drake University, who is the Plan Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who is Entitled to Elect COBRA?”

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO’s may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this SPD.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee's hours of employment are reduced;
- the employee's employment ends for any reason other than his or her gross misconduct;
- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same eighteen (18) month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notifies the Plan Administrator in writing within sixty (60) days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed, or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Plan Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Plan Administrator. Under federal law, the participant must have sixty (60) days after the date the qualified beneficiary plan coverage terminates, or, if later, sixty (60) days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The Election Form must be completed in writing and mailed to the address specified above. The

following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than sixty (60) days after the date of the COBRA election notice provided at the time of the qualifying event.

IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

The participant does not have to send any payment with his/her Election Form when he/she elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the sixty (60) day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail

below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having preexisting condition exclusions applied to the participant by other group health plans if he/she has a sixty-three (63) day gap in health coverage, and election of COBRA may help to not have such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if he/she elect COBRA coverage and do not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within thirty (30) days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of thirty-six (36) months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to thirty-six (36) months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of eighteen (18) months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Plan Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This

extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first sixty (60) days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Plan Administrator in writing of the Social Security Administration's determination of disability within sixty (60) days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period and within eighteen (18) months after the covered employee's termination of employment or reduction of hours,

THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability extension, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under

the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Plan Administrator in writing of the second qualifying event within sixty (60) days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than thirty (30) days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no

longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Plan Administrator of that fact within thirty (30) days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than thirty (30) days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Drake University will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period)."

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to CTIA COBRA Account and mailed to:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than forty-five (45) days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on

or before December 30, the 45th day after the date of her COBRA election. The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Plan Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and make the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within forty-five (45) days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of thirty (30) days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month,

HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Drake University during the covered employee's period of employment with Drake University is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if the participant is not sure whether this is the Plan's most recent SPD, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows you to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that you would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that you pay no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions you make. Furthermore, your premium is also exempt from state income taxes in most states. This means a higher take-home pay for you, than if you purchased this Plan with after-tax dollars.

The pre-tax premium program is available to you if you meet the eligibility requirements under this Plan. Your premium will automatically be deducted from your paycheck on a pre-tax basis.

Your enrollment regarding the tax status of your premiums will continue in effect until you change it. You can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if you experience a family status change, as defined by the Internal Revenue Service.

Your choices are in effect for the entire Plan Year. Only under special circumstances, such as changes in family status including, but not limited to: marriage, divorce, legal separation, death of a spouse or child, birth or adoption of a child, the termination or commencement of your spouse's employment, a significant increase in your costs with respect to this Plan, the switching from part-time to full-time employment status, or the reverse,

by you or your spouse or the taking of an unpaid leave of absence by you or your spouse, may you apply to change your selected benefits. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

Note: Because the premium contributions you make to this Plan are not taxed as wages for Social

Security purposes, your ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including your earnings history, whether you are above or below the Social Security "wage base," and what happens to the Social Security laws between now and when you retire.

DESCRIPTION OF DENTAL BENEFITS

HOW THE DENTAL PLAN WORKS

Deductible

You will be responsible for a deductible per calendar year as stated in the Benefit Summary before any benefits will be paid by this Plan, unless otherwise specified in the benefit summary.

Coinsurance

Once you have satisfied your deductible amount, this Plan will pay the coinsurance percentages of the covered dental expenses outlined in the benefit summary.

Plan Maximums

The maximum dental benefit you and each of your covered dependents can receive under this Plan is stated in the Benefit Summary.

DENTAL BENEFITS

Covered dental benefits are limited to the lesser of the amount charged or the maximum allowable fee for the geographic area in which treatment was received. Dental benefits paid by this Plan will not exceed the maximum amount specified by this Plan.

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

Preventive Dental Benefits

Preventive dental benefits include:

- routine oral examinations - limited to twice per calendar year;
- dental x-rays - limited to full mouth x-rays once every thirty-six (36) months and bitewing x-rays twice per calendar year;
- prophylaxis (teeth cleaning) - limited to twice per calendar year;
- non-routine, non-emergency office visits;

- emergency treatment office visits;
- topical application of fluoride for dependent children - limited to one application per twelve (12) month period;
- space maintainers -limited to dependent children under age fourteen (14);
- biopsy of oral tissue;
- sealants - limited to dependent children under age fourteen (14) and to once every four years per quadrant;
- other x-rays (e.g., periapical x-rays).

Basic Dental Benefits

Basic dental benefits include:

- restorations - regular cavity fillings, including amalgam, synthetic porcelain and plastic fillings, under local anesthesia;
- repair of crowns, bridges and dentures;
- recementing of space maintainers;
- simple tooth extractions and removal of impacted teeth except those removed on a hospital inpatient basis when the patient has a non-dental physical condition which requires inpatient hospitalization-these are considered under the medical plan;
- oral surgery, including anesthesia;
- treatment for inflammation of the gums, including consultations for periodontic conditions and periodontic prophylaxis. Surgical procedures are limited to one service per quadrant per twelve (12) month period;
- scaling and root planing - limited to once every six (6) months;
- denture relining - limited to relinings more than one year after the initial denture installation and not more than once every two (2) years;
- periodontic appliances - limited to one every three (3) years;
- endodontic dental care (root canal therapy).

For individuals applying for coverage at other than the time they are first eligible or during a special enrollment period, basic dental benefits described above are deferred for six (6) months following the individual's effective date unless services are to treat an accidental injury.

Major Dental Benefits

Major dental benefits include:

- gold foil restorations - only if tooth cannot be restored by a silver filling and, for replacements, it has been at least five (5) years since last replacement;
- inlays, and onlays utilized as restorations;
- removable or fixed bridges;
- crowns--acrylic, acrylic with gold, acrylic with nonprecious metal, porcelain with gold, porcelain with nonprecious metal, or gold (gold crowns are covered only if teeth cannot be restored with a filling material and nonprecious metal);
- pontics (artificial teeth)--cast gold, cast non-precious metal, porcelain fused to gold, porcelain fused to nonprecious metal, plastic processed to gold, or plastic processed to nonprecious metal;
- dentures—complete upper or lower partial dentures, laboratory reline, denture duplication (jump case).

For individuals applying at other than the time they are first eligible or during a special enrollment period, major dental benefits described above are deferred for twelve (12) months following the individual's effective date unless services are to treat an accidental injury.

DENTAL BENEFIT PRETREATMENT ESTIMATE

If your dentist estimates the charges for your dental care will exceed \$200, it is recommended you submit a pretreatment estimate to First Administrators, Inc. prior to receiving dental care. The pretreatment estimate will be returned to your dentist explaining the benefits to which you are entitled.

ALTERNATE TREATMENT PLAN

Many dental problems can be treated in more than one way. This Plan will allow benefits for generally accepted treatment providing adequate dental care is provided at the lowest cost to you.

If you pursue a more expensive course of treatment, this Plan will pay the equivalent of the least expensive treatment which adequately restores the mouth to normal form and function.

DENTAL EXCLUSIONS

The dental program does not cover the following charges:

- (1) cosmetic dental services (including laminates and veneers);
- (2) replacement of lost or stolen dentures;
- (3) crowns or other appliances whose primary purpose is periodontal splinting, altering vertical dimension, or correcting occlusion;
- (4) replacement of lost or stolen dental appliances;
- (5) acupuncture;
- (6) personal convenience items;
- (7) infection control procedures;
- (8) occlusal adjustments;
- (9) occlusal orthotic devices;
- (10) repair of space maintainers;
- (11) tooth reimplantation;
- (12) vestibuloplasty;
- (13) local anesthesia or analgesia;
- (14) provisional splinting;
- (15) dental implants;
- (16) orthodontic services;
- (17) services or supplies for the treatment of TMJ;
- (18) anesthesia, except for oral surgery;
- (19) dental service(s) provided by a government agency;
- (20) full or partial dentures or bridgework made exclusively for the replacement of teeth which were extracted prior to your effective date under this Plan will not be covered for the first twenty-four (24) months following your effective date;
- (21) replacement of any prosthetic appliance, crown, inlay or onlay, restoration or fixed bridge within five (5) years of the date of the last placement, unless the patient has been covered by the Plan for twelve (12) consecutive months or if the replacement is due to an accident;
- (22) charges for dental care that exceed the usual, customary and reasonable amount;

- (23) cost of travel or lodging to receive dental treatment;
- (24) charges for the replacement of any prosthetic appliance, crown, inlay or onlay restoration or fixed bridge within five (5) years of the date of the last placement, unless the replacement is necessary due to an accident sustained while covered by this Plan;
- (25) splinting or replacing tooth structure lost by abrasion or attrition;
- (26) oral hygiene, a plaque control program or diet instructions;
- (27) charges for dental implants;
- (28) charges for any appointment that a participant fails to keep;
- (29) charges for completing claim forms;
- (30) expenses resulting from war or any act of war;
- (31) any loss sustained while on active duty with any armed forces;
- (32) charges for services a covered person is not legally required to pay;
- (33) charges for which you would not be responsible in the absence of this Plan;
- (34) expenses incurred prior to a participant being covered by this Plan;
- (35) any surgery or other type of dental treatment performed on an elective, non-dentally necessary basis;
- (36) experimental and research-oriented dental procedures;
- (37) a service for which there is no charge, or a service performed by a family member or a person who resides with the patient;
- (38) personal convenience items such as electric toothbrushes, dental floss, etc.;
- (39) services of an individual who is not a dentist or dental hygienist;
- (40) services of any person in a patient's immediate family;
- (41) drugs and medicines (other than antibiotic injections);
- (42) bite registration or occlusal analysis;
- (43) treatment or services that result from voluntary participation in criminal activities; and
- (44) treatment or services for which benefits are payable under the medical plan.

OTHER FACTS YOU SHOULD KNOW ABOUT YOUR DENTAL PLAN

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when you (or a family member) have other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under your other coverage, will not be more than 100% of either our payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance; other group benefit plans (e.g., 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 us coordinate your benefits, you should:

- Inform your provider by giving him/her information about your other coverage at the time you receive services. Your provider will pass the information on to us 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. You will receive a letter from us if we need any additional information.

It is important that you provide us with the requested information concerning your other coverage. If you do not give us the necessary information, your claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without a COB clause will be primary.
- (b) Any dental benefits of your auto coverage will pay before this Plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to dental insurance or dental benefit plans.
- (c) If both plans have a COB clause, the plan covering you as an employee will be primary over the plan covering you as a dependent.
- (d) If you are the main person covered under both plans (you are not a dependent under either plan), the plan that has provided coverage the longest will be primary.
- (e) The plan covering you as an active participant will pay before the plan covering you as an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants.
- (f) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children.
- (g) If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- (h) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent.
- (i) If none of the guidelines listed above apply, the plan which has covered you or your dependent the longest will be primary.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision (***established so a covered person cannot profit from this Plan***), the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- any persons to whom such payments were made; or
- any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of dental insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of

Covered Employee or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or

pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or,
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the

prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Wrongful Death Claims

In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Beneficiary's obligation:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset

Failure by the Plan Beneficiary and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights.

Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan, as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

CONFORMITY WITH LAW

To the extent not pre-empted by ERISA, this Plan shall be governed by the laws of the state of Iowa. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

CLAIMS FILING AND APPEALS

ASSIGNMENT OF BENEFITS

This Plan accepts all assignments of benefits to make direct payments to providers of service. Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion may terminate his/her interest in any such amount and will hold or apply it to or for the benefit of the participant, his/her spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

Claims must be received within twelve (12) months of the day charges are incurred to be eligible for benefits.

Whenever you obtain services you should present your identification card. Instructions for billing by the provider of care or the member are included on the member identification card. Providers may file claims for you; however you are ultimately responsible for the filing of your claims.

A paper claim will be considered filed when a claim has been received by the Benefit Services Administrator. Electronic claims are considered received the day subsequent to the transmission of the claim by the provider. There are specific fields that are required for each type of claim to constitute a "clean claim". This criteria is available, upon request, from the Benefit Services Administrator.

For claims not filed by the provider of service, the following steps should be taken to ensure that claims are filed correctly. Your employer will provide you with claim forms.

- (1) Claims must be received within twelve (12) months of the day charges are incurred.

- (2) Complete the personal section of the claim form. Be sure to indicate any other group, franchise or association-sponsored plan you have in addition to this Plan.
- (3) Sign the assignment of benefits portion of the claim. Unless assigned, benefit payments will be directed to you.
- (4) Either have the provider complete the appropriate section or attach the original itemized bill to the claim form. This bill should identify the patient, the date, the nature of treatment or service and the amount charged. Canceled checks or cash receipts do not contain the information needed to process a claim.
- (5) Sign and date the form in the authorization section.
- (6) Use a separate claim form for each member of the family and retain a copy for your files.
- (7) All claims should be mailed to:

First Administrators, Inc.
Claims Department
PO Box 9900
Sioux City, IA 51102-0479

CLAIM DETERMINATION

This section describes the procedures the Plan will follow in making a determination on a claim for benefits. A claim is any request for a plan benefit, made by a claimant or a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims.

Upon receipt of a claim, the Plan must respond to the participant within the time frames stated below. These time frames are the maximum number of calendar days in which a determination must be made and communicated to the participant.

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The participant's physician may determine if the claim is an urgent care claim. Otherwise, an individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

A response to an urgent care claim will be provided within seventy-two (72) hours of the receipt of the claim by the Plan. If a participant fails to provide sufficient information, the Plan will notify the participant within twenty-four (24) hours of receiving the claim of the specific information necessary to complete the claim. The participant will then have forty-eight (48) hours to provide the additional information and, once received, a decision will be communicated within forty-eight (48) hours. Without complete information, the claim will be denied.

Pre-Service Claims

A pre-service claim is any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If the participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the participant of the failure and the proper procedures to be followed within five (5) days of such failure. Otherwise, a response to a pre-service claim will be provided within fifteen (15) days of the receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial fifteen (15) day period, the circumstances requiring the extension, and will be given the date by which a decision is expected. If the extension is necessary due to the failure of the participant to provide sufficient information, the Plan will notify the participant of

the specific information necessary to complete the claim. The participant will then have forty-five (45) days to provide the additional information and, once received, a decision will be communicated within fifteen (15) days. Without complete information, the claim will be denied. If the Plan does not provide a notice of extension within fifteen (15) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedure section.

Concurrent Care Claims

Concurrent Care is an ongoing course of treatment (inpatient or outpatient) to be provided over a period of time or number of treatments which has been approved by the Plan. If ongoing treatment benefits are reduced or terminated by the Plan before the end of the period for which such treatment was approved, the participant will be notified sufficiently in advance to allow the participant to appeal the adverse determination and obtain a decision on the appeal before the reduction or termination goes into effect.

If a participant requests an extension of a course of treatment that is an urgent care claim as defined above, the Plan will notify the participants of its determination within twenty-four (24) hours of the Plan's receipt of the request.

If the participant requests an extension of a course of treatment that is not an urgent care claim, the request will be considered a new claim and will be subject to the time frames and procedures that are appropriate to the type of claim (i.e., pre-service or post-service). Please refer to the appropriate section for timelines and procedures specific to these types of claims.

Post-Service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

The Plan will respond to a post-service claim within thirty (30) days of receipt. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial thirty (30) day period and will be given the date by which a decision is expected. If the Plan does not provide a notice of extension within thirty (30) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedure section.

If a participant fails to provide sufficient information, the participant will be notified within thirty (30) days of the Plan's receipt of the claim of the specific information necessary to complete the claim. The participant will then have forty-five (45) days from receipt of the notice to provide the additional information, and once received, a decision will be communicated within fifteen (15) days. Without complete information, your claim will be denied.

NOTIFICATION OF DECISION

If a claim has been wholly or partially denied, written notification will be provided by the Plan which will describe:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provision(s) on which the denial is based;
- (c) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) an explanation of this Plan's claims review procedure, including a statement of the claimant's right to bring civil action under ERISA section 502(2) following an adverse benefit determination;
- (e) a copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or in lieu thereof, a statement that such information is available free of charge upon request;
- (f) an explanation of the scientific or clinical judgment relied upon in denying the claim based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (g) for urgent care claims, a description of the expedited appeal process.

For urgent care claims, this information may be provided to the participant orally, provided that written notification is furnished within three (3) days of the oral notification.

CLAIM REVIEW PROCEDURE

Claim Inquiry

If a claim has been wholly or partially denied, and if the claimant does not agree with the decision to reduction, or if the claimant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the claimant has the right to a full and fair review. An

adverse benefit determination is a denial reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the notification of decision. This request must be submitted within 180 days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the Urgent Care Claim section below.

The claimant may submit written comments, documents, or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in your case will be consulted. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the claimant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

Notification of the decision on appeal will be provided within seventy-two (72) hours of the Plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within thirty (30) days of the Plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent

care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within sixty (60) days of the Plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the Plan that will describe:

- (a) specific reason(s) for adverse determination;
- (b) reference to the specific Plan provision(s) on which determination is based;
- (c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to, and copies of all documents, records and other information relevant to the participant's claim for benefits;
- (d) a statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures, as well as the right to bring civil action as described in ERISA Section 502(a);

- (e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request;
- (f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request.

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by you, and include all the information required in our Authorized Representative Form. This form is available from your employer. In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

DEFINITIONS

"ABUTMENT" means a tooth or root that retains or supports a fixed bridge or a removable prosthesis.

"ACCIDENTAL INJURY" means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance.

"ACID-ETCH" means, in restorative dentistry, a method of etching the tooth enamel with an acid to provide adhesion of composite filling material to a tooth surface.

"ACTIVELY AT WORK" means the performance of the essential functions of the participant's regular position, with or without reasonable accommodation, at the participant's normal place of work or any other location directed by Drake University.

"ACTIVELY AT WORK ON A FULL-TIME BASIS" means an employee must work for Drake University at his normal place of work or such other place or places as directed by Drake University in the course of such work for at least nine months per calendar year and no less than thirty two (32) hours per week.

"ADJUSTMENT" means an alteration or modification which may be required on a denture or the teeth in a denture after it has been placed in the mouth.

"ADOPTED CHILD(REN)" means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

"ALLOWABLE EXPENSES" mean the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan. This calculation is based on the payment method utilized by this Plan.

"ALTERNATE RECIPIENT" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

"ALVEOPLASTY & ALVEOLECTOMY" means surgical excision or revision of the alveolar process to restore a normal contour. These procedures may range from simple alveolectomy in conjunction with extractions to reconstruction of the ridge in preparation for dentures.

"AMALGAM" means an alloy of mercury, silver and other metals used as a restorative material and in making dies.

"AMENDMENT" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by Drake University.

"ANTERIOR" means in the front; the incisors and cuspids.

"APICOECTOMY" means surgical removal of the apical portion of a tooth root.

"APPLIANCE" means a device used to replace missing parts or restore function, such as a denture, splint or obturator.

"BENEFIT SERVICES ADMINISTRATOR" means First Administrators, Inc. an Iowa corporation.

"BENEFITS" mean those dentally necessary services and supplies that qualify for payment under this Plan.

"BICUSPIDS" mean the two teeth in each quadrant that are posterior to the cuspids and anterior to the molars. Also called premolars.

"BITE GUARD" means an appliance that covers the occlusal and incisal surfaces of the teeth. It is used to stabilize the teeth and/or provide a flat surface for unobstructed movement of the mandible.

"BITEWINGS" mean dental X-rays showing approximately the coronal halves of the maxillary and mandibular teeth on the same film.

"BRIDGE" means a permanently cemented appliance which includes at least one pontic (to replace a missing tooth) and at least one abutment. Bridges are removable only by a dentist.

"BRUXISM" means a clenching or grinding of the teeth, associated with a forceful jaw movement, usually during sleep.

"BUSINESS ASSOCIATE" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also

see Part II, 45 Code of Federal Regulations Part 160.103).

"CALENDAR YEAR" means the twelve (12) month period commencing January 1 and ending the next following December 31.

"CARIES" mean a progressive destruction of the teeth from bacterially produced acids on tooth surfaces.

"CAVITY" means a carious lesion in a tooth.

"CHILD(REN)" means unmarried child(ren) of a covered employee, under age nineteen (19), including natural children, adopted children (as defined), stepchildren, grandchildren or children for whom the employee has legal guardianship who are unmarried.

"CLAIM" means any request for a Plan benefit made by a claimant or a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims.

"CLASP" means a metal attachment on partial dentures or other removable appliances to hold them in place.

"COINSURANCE" means the percentage(s) of eligible expenses allocable to the participant and the employer after any applicable co-pays, calendar year deductibles, or non-compliance penalties have been applied.

"COMPLETE DENTURE" means an appliance which replaces all of the teeth in an arch.

"COMPOSITE" means a plastic restorative material made of resin and quartz crystals blended with a catalyst, (e.g., Blendant, Adaptic, Nurvafil, Epoxylite, Compodent, Concise, Smile, Enamelite and Restodent).

"COVERED DENTAL EXPENSES" mean expenses incurred which are dentally necessary and which are specified covered services of this Plan.

"COVERED DEPENDENT" means a spouse or a dependent child who has satisfied the definition of dependent and the eligibility requirements specified in this Plan.

"COVERED EMPLOYEE" means any employee who is eligible for benefits as specified in this Plan.

"COVERED EXPENSES" means those expenses covered by this Plan, including the dental care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not dentally necessary, are experimental or investigational in nature, or if they exceed the maximum amount considered by this Plan. See also the definitions of eligible expenses and allowable expenses.

"CROWN" means the portion of the tooth above the cemento-enamel junction.

- **Anatomic Crown** - The portion of a tooth exposed beyond the crest of the gingiva.
- **Complete Crown** - A crown that covers the entire clinical crown.
- **Dowel Crown** - A complete (full) crown that replaces the entire coronal portion of the natural tooth, which is retained by a post extending into the root canal.
- **Face Crown** - A metal crown with a tooth-colored material on the labial or buccal surface.
- **Jacket Crown** - Generally a complete veneer crown that is made entirely of porcelain or acrylic resin.
- **Partial Crown** - A crown that covers only a portion of a tooth (e.g., one half or three-quarters of its circumference).
- **Shell Crown** - A metal cap designed to fit the prepared tooth. (Usually pre-formed to reproduce the natural crown.)
- **Telescope Crown** - A preparation placed over remnants of a natural tooth to give strength to the restoration.
- **Veneer Crown** - Full coverage crown made by acrylic, porcelain, metal or combinations of metal with acrylic or porcelain.

"DEDUCTIBLE" is the amount for covered services you pay before this Plan begins paying benefits.

"DENTALLY NECESSARY" means that a procedure, service or supply is all of the following:

- appropriate and necessary for the diagnosis and treatment of your dental condition;
- consistent with professionally recognized standards of dental care determined within the state in which you reside and given at the right time and in the right setting;

- not more costly than alternative services that would be effective for diagnosis and treatment of your condition; and
- enables the patient to make reasonable progress in treatment.

"DENTIST" means a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.

"DENTURE" means a prosthesis which replaces missing teeth.

- **Full Denture** - A prosthesis which replaces all natural teeth in an arch.
- **Partial Denture** - A prosthesis which replaces fewer than the full number of natural teeth in either jaw.

"DEPENDENT" means any one or more of the following:

- The spouse/domestic partner of an employee;
- Unmarried children of an employee under the age of nineteen (19), including natural children, adopted children (as defined), stepchildren, grandchildren for whom the employee or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee has been granted legal custody;
- Unmarried children of an employee including natural children, adopted children (as defined), stepchildren, grandchildren for whom the employee or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee has been granted legal custody who have attained age nineteen (19) but who have not attained age twenty-six (26) and who are full-time students in an accredited educational institution; and
- Unmarried children of an employee, natural children, adopted children (as defined), stepchildren or grandchildren for whom the employee or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee/domestic partner has been granted legal custody are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced

prior to attainment of the termination age specified in this Plan and such children were covered prior to attainment of such age and continuously thereafter under this Plan or a predecessor plan.

"DIAGNOSTIC CAST" means a positive replica of the teeth and tissues made from an impression; also called a study model.

"DISABLED" means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to engage in the normal activities of a person in good health of like age and sex.

"DOMESTIC PARTNER" means an individual who:

- is at least eighteen (18) years of age and of the same gender as the employee;
- has executed a notarized "relationship contract", which obligates each partner to provide support for the other and to act as each other's sole domestic partner indefinitely;
- is not able to qualify for coverage as a common law spouse;
- is not legally married or covered under any other domestic partnership arrangement with Drake University;
- is not related by blood closer than would bar marriage in the state of Iowa, and each partner is mentally competent to consent to the contract; and
- the partners have been residing together for at least six (6) continuous months immediately prior to filing the "Affidavit of Domestic Partnership".

"DOWEL POSTS AND PINS" mean pins or posts placed in a tooth to provide retention for a crown.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. If the course or manner of treatment of a condition is expressly excluded by this Plan, is not medically necessary, is experimental, investigational or otherwise regarded by the Plan Administrator to be ineffective treatment for the condition, or not included because

of any reason described in the Plan, then the expense for the treatment is not eligible. See the definition of allowable expense for a description of how this Plan computes the portion of an eligible expense which it will pay.

"EMPLOYEE" means any individual who is employed by the company.

"ENAMEL" means the white, hard substance that covers the coronal portion of teeth and protects the dentin.

"ENROLLMENT DATE" or "DATE OF ENROLLMENT" means the first day of a participant's waiting period under this Plan (typically, the date the employee's employment begins). The enrollment date for a late enrollee, or anyone who enrolls during a special enrollment period, is the first day of coverage under this Plan. For those to whom no waiting period applies, the enrollment date is the date of employment.

"EQUILIBRATION" means the study and achievement of equalized pressure; the balancing of opposing forces such as the maxilla with the mandible.

- **Extensive Equilibration** - A diagnostic study involving the use of study models, articulator and registrations to determine need for and type of occlusal correction.
- **Occlusal Equilibration** - The correction of occlusion by selective grinding to equalize occlusal stress or for harmonizing cuspal relations by removing high spots and areas of interference.

"ERISA" means the Employee Retirement Income Security Act of 1974, a federal law protecting your rights under this Plan.

"ERUPTION" means the process of erupting; the appearance of a tooth breaking through the gingival tissues; the cutting of a tooth.

- **Surgical Eruption** - Surgical removal of overlying tissue, bone, cyst or tumor to permit eruption.

"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES" mean that one or more of the following is true:

- (a) the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;

- (b) the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device, treatment or procedure as being experimental or investigational;
- (c) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; and/or
- (d) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

"EXTRACTION" means removing a tooth from the oral cavity.

- **Simple Extraction** - Uncomplicated removal of a tooth.
- **Surgical Extraction** - Removal of a tooth by means of surgical methods, usually involving the turning of a flap or removal of bone.

"FILLING" means restoration. By common usage filling refers to a restoration which does not require casting, but is more accurately a temporary restoration.

- **Treatment Filling** - A sedative filling, temporarily placed, for treatment of sensitive dentin in preparation for a final restoration. (Used when the extent of disease cannot be determined until the demineralized dentin is hardened to permit removal without pulp exposure.)

"FIXED APPLIANCE" means an appliance that is permanently cemented or attached with adhesive materials.

"FIXED BRIDGE" means a prosthesis that replaces one or more teeth and is cemented into place. It consists of one or more pontics held in place by one or more retainers or abutment teeth.

"FLUORIDE" means a solution of fluorine which is applied to the teeth for the purpose of preventing dental caries.

"FULL-TIME STUDENT" means a covered dependent who meets the age requirements of this Plan, is enrolled in a full-time (as defined by the institution they are attending) course of study in an approved institution of higher learning and is principally dependent upon the covered employee, covered spouse/domestic partner for his/her support and maintenance as defined by the Internal Revenue Service for tax purposes. Dependents who are attending, full-time, other institutions for advanced education (i.e. trade schools), will also be considered full-time students.

"GINGIVECTOMY" means excision of diseased or unsupported gingival tissue.

"GINGIVITIS" means inflammation of the gingival tissue.

"HIPAA" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and

privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

"IMMEDIATE FAMILY" means a participant's legal spouse/domestic partner, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMPACTED TOOTH" means a tooth that is positioned or wedged against another tooth, or covered by bone or soft tissue, so that it cannot erupt.

"IMPLANTS" mean dental implants made of metal or other foreign material and placed into or on the alveolar bone to provide support.

"INJURY" means a physical condition which is the result of an accident caused by an external force and occurring while this Plan is in effect, with respect to that participant, and which results in loss covered by this Plan; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INLAY" means a cast restoration made to fit a prepared tooth cavity and then cemented into place.

"LATE ENROLLEE" means a participant or beneficiary who enrolls under this Plan other than during: (a) the first period in which the individual is eligible to enroll under this Plan; or (b) a special enrollment period.

"MALOCCLUSION" means an abnormality in the positioning and relationship of teeth.

"MANDIBLE" means the lower jaw.

"MAXILLA" means the bone forming one-half of the upper jaw. The upper jaw consists of two maxillae. It is commonly referred to as the maxilla.

"MAXILLOFACIAL" means pertaining to the jaws and the face.

"MAXIMUM ALLOWABLE FEE" means an amount established, using various methodologies, for covered services and supplies. The settlement amount is based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to you. Upon receiving your request for such information, First Administrators, Inc. or your group health plan sponsor will provide the following:

- the frequency of the determination of the maximum allowable fee;
- a general description of the methodology used to determine the maximum allowable fee, including geographic locations; and
- the percentile that determines the maximum benefit that we will pay for any procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims and then determining the benefit by selecting a percentile of those fees.

"OCCLUSAL GUARD" means a removable dental appliance, usually constructed of acrylic resin, that covers one or both dental arches to protect the teeth from the damaging effects of bruxism and other occlusal habits.

"OCCLUSION" means the contact of the teeth of both jaws when they are closed.

"ONLAY" means a cast restoration that covers the entire incisal or occlusal surface of a tooth.

"OSSEOUS SURGERY" means surgery performed to eliminate osseous deformities; to remove diseased and defective bone tissue.

"OVERLAY" means an inlay or a splint that fits over the biting or grinding surface of a tooth.

"PALLIATIVE" means affording temporary relief, but not a cure.

"PARTIAL DENTURE" means a prosthesis which replaces one or more, but not all, natural teeth and associated structures; may be removable or fixed, unilateral or bilateral.

"PARTICIPANT" means any covered employee and any covered dependent.

"PERIODONTAL" means situated or occurring around a tooth; pertaining to the periodontal membrane.

"PERIODONTITIS" means the inflammation of the tissues surrounding a tooth.

"PHYSICIAN" means a legally licensed Dental Doctor (DMD, DDS), provided he is licensed in the political jurisdiction where practicing and is acting within the scope of that license. The term physician will not include the employee, his spouse, children,

brothers, sisters, parents, or any other person residing in the patient's household.

"PLAN" means this Drake University Dental Plan, as set forth herein, and as from time to time amended, which is administered by First Administrators, Inc., the Benefit Services Administrator.

"PLAN ADMINISTRATOR" means the person or persons appointed to administer this Plan, if any, otherwise, the company.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also see Part II, 45 Code of Federal Regulations Part 164.501).

"PLAN YEAR" means the twelve (12) consecutive month period commencing on June 1 and ending on the next following May 31.

"PONTIC" means the part of a fixed bridge that is suspended between abutments and that replaces a missing tooth: an artificial tooth in a removable denture.

"POST" means, in partial denture work, the minor connector that attaches the clasp body to the framework or an upright metal device that extends into a tube tooth to retain it. In restorative dentistry, a metal projection in crowns for strength which may extend into the root of a pulpless tooth or through the root into the alveolar bone.

"POST AND CORE" means a single cast unit that is placed into a tooth, followed by permanent exterior restoration, usually a crown.

"PRECISION ATTACHMENT" means a specially designed attachment used in fixed and removable prosthetics, for attachment to the abutting teeth. This attachment usually consists of a tongue and groove, or male-female design.

"PROPHYLAXIS" means the cleaning of teeth by a dentist or dental hygienist.

"PROSTHESIS" means an artificial replacement for one or more natural teeth and/or associated structures.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

"PULP" means the connective tissue that fills the pulp chamber and root canals of teeth.

"PULPECTOMY" means complete removal of either vital or inflamed pulp from the pulp chamber and root canals.

"PULPOTOMY" means removal of dental pulp from the coronal portion of a tooth.

"QUADRANT" means one-fourth of the two dental arches; one-half of each arch.

"QUALIFIED BENEFICIARY" means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child, and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

"REBASE" means the repair or alteration of the base of an artificial denture.

"RELINE" means the resurfacing of the tissue-borne areas of a denture with new material.

"RESTORATION" means fillings, inlays, crowns, bridges, partial and complete dentures.

"RETAINER" means an abutment tooth in a fixed bridge that may be an inlay or a partial or full crown. In removable prosthetics, a clasp, attachment or device used for fixation or stabilization. In orthodontics, an appliance used to maintain the altered positions of the teeth and jaws until they stabilize.

"ROOT CANAL" means the space within the root of a tooth that contains nerves and blood vessels.

"ROOT CANAL THERAPY" means treatment of a tooth having a diseased or damaged pulp. Root canal therapy usually consists of the complete removal of the pulp, sterilization of the pulp chamber and root canals, and filling those spaces with a sealing material.

"ROOT PLANING" means the smoothing of roughened root surfaces by the use of scalers and curettes.

"SCALE" means the removal of calculus (tartar) and stains from the teeth with a scaler.

"SEALANT" means a resin (plastic) material placed on the occlusal surfaces of permanent bicuspid and molars to prevent decay.

"SEALER" means a material used to fill the space around silver or gutta-percha points in root canal therapy.

"SPACE MAINTAINER" means a fixed or removable appliance placed to maintain space created by premature loss of one or more teeth. A space maintainer may also be used to create space by moving teeth apart.

"SPLINT" means an appliance designed to retain teeth in position.

"SPLINTING" means stabilizing or immobilizing periodontally-involved teeth. Splinting may be accomplished with acrylic resin bite guards, orthodontic band splints, wire ligation, provisional splints and fixed prostheses.

"SPOUSE" means a person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence. In addition, if you are a covered employee and have a common law marriage or domestic partnership, coverage for your spouse/domestic partner and dependent children may be obtained. However, certain requirements must be met, as determined by the company and by the laws of the state in which you live. Please contact the company for specific details.

"STEPCHILD" means any unmarried biological or adopted child of the spouse of an employee who has not reached the age of nineteen (19), and any unmarried biological or adopted child of the spouse of an employee who has not yet reached the age of twenty-six (26) and is a full-time student in an accredited school.

"SURFACES" mean any one or more of the following:

- **Buccal Surface** - Adjacent to the cheek.
- **Distal Surface** - Away from the median plane of the face, following the curvature of the dental arch.
- **Facial Surface** - Next to the face.
- **Incisal Surface** - Cutting surface of anterior teeth.
- **Labial Surface** - Same as facial, but towards the mouth and lips.

- **Lingual Surface** - Adjacent to the tongue.
- **Mesial Surface** - Toward the center or median line of the dental arch.
- **Occlusal Surface** - The masticating or grinding surface of molars and bicuspids.
- **Proximal Surface** - The surface nearest to the adjacent tooth.

"TOTAL DISABILITY" and "TOTALLY DISABLED" mean:

- (a) In the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the material duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience;
- (b) In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

"TREATMENT PLAN" means a dentist's report on a form satisfactory to the Benefit Services Administrator which itemizes the dental services recommended by the dentist for the necessary dental care of a participant, shows the dentist's charge for each dental service, and is accompanied by supporting preoperative x-rays or other diagnostic records where required or requested by the Benefit Services Administrator.

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

STATEMENT OF RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are provided to you below, as required by federal law and regulation.

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, bargaining agreements and copies of all documents such as annual reports (Form 5500) filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

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

Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months

after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of this employee benefit Plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused this Plan.

The employer of a Plan participant may not fire or discriminate against that participant to prevent him or her from obtaining or exercising his or her rights under ERISA.

Enforce Your Rights

If a participant is denied a benefit in full or in part, he or she has a right to know why this was done, to obtain copies of the 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 thirty (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 administrator. If you have a claim for benefits which is denied or ignored, in full or in part, you may file suit in a state or Federal court. In addition, if a participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in Federal court. If Plan fiduciaries are misusing this Plan's money, or if a participant is discriminated against for asserting his or her rights, a participant has the right to file a suit in a Federal court or request assistance from the U.S. Department of Labor. If the participant is successful in the lawsuit, the court may require the other party to pay the participant's legal costs, including attorney's fees. If the participant is unsuccessful, the court may

require the participant to pay these costs and fees, for example if it finds the claim was frivolous.

Assistance with your Questions

If a participant has any questions about this Plan, the participant should contact the Plan Administrator. If the participant has any questions about this statement or about his or her rights under ERISA, or if the participant needs assistance in obtaining documents from the Plan Administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S.

Department of Labor, listed in their 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. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INFORMATION REQUIREMENTS OF ERISA

Named Fiduciary/ Plan Sponsor:	Drake University 1331 27 th Street, The Point Des Moines, Iowa 50311
Employer Identification #:	42-0680460
Plan Number:	501
Group Number:	92400
Plan Year Ends:	May 31st
Participants:	All active full-time employees
Plan Administrator and Agent for Legal Process of Plan:	Drake University 1331 27 th Street, The Point Des Moines, Iowa 50311
Plan Costs:	The Plan Sponsor and the employees pay the costs of this Plan.
Type of Benefits:	Dental Benefits
Type of Administration:	Contract Administration
Third Party Administrator:	First Administrators, Inc. PO Box 8150 Rapid City, SD 57709-8150
Authority to Amend Plan:	President of Drake University or his/her designee
Administration and Plan Administrator Authority:	<p>The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.</p> <p>The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.</p> <p>The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently</p>

If your employer is unable to fund this Plan, you may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

NOTES