DELTA DENTAL PPO
SUMMARY OF BENEFITS
FOR COVERED EMPLOYEES OF:

Silver Lake School District

(See Dental Benefit Handbook for definitions of capitalized terms.)

GROUP NUMBER: 07312 - 00000

EFFECTIVE DATE OF PROGRAM: August 1, 2012

OPEN ENROLLMENT

Changes in enrollment status will be considered during an Open Enrollment Period 30 days prior to the Contract renewal date, with changes becoming effective on the renewal date.

WAITING PERIOD

Employees and their Dependents who apply for coverage after their initial eligibility period or without a qualifying event (loss of spousal benefits, marriage, divorce, birth or adoption, or the loss of employee coverage through another insurer) will:

Wait until the next Open Enrollment Period.

TERMS OF ELIGIBILITY

Eligibility begins:
For eligible new employees, eligibility begins the first day of the month following the waiting period.

For eligible new employees, the waiting period is 30 days.

For employees enrolling their Dependents:
Dependent children are eligible to the date on which they attain age 26, regardless of student status, or if age 26 and beyond, to the date they lose eligibility due to the Dependent's inability to meet all of the requirements contained in the Handbook.

Part-time employees are covered; minimum hours worked are to be determined by the group.

DEDUCTIBLE LIMITATIONS

Delta Dental shall not be obligated to pay any Deductible specified below.

The Deductible for Dental Procedures provided by Delta Dental PPO Dentists is $50 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $150 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

The Deductible for Dental Procedures provided by Delta Dental Premier Dentists is $50 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $150 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

The Deductible for Dental Procedures provided by Noncontracted Dentists is $50 per Subscriber and per Covered Dependent, per Benefit Accumulation Period; however, no family will pay more than $150 per Benefit Accumulation Period in Deductibles regardless of the number of family members covered.

MAXIMUM BENEFIT

The maximum total Benefit payable in any Benefit Accumulation Period is limited to the amount specified below.

The maximum total Benefit per Subscriber and per Covered Dependent, per Benefit Accumulation Period for Dental Procedures provided by Delta Dental PPO Dentists is $1,500, and $1,500 for Dental Procedures provided by Delta Dental Premier Dentists, and $1,500 for Dental Procedures provided by Noncontracted Dentists. In no case will the maximum total Benefit exceed $1,500 regardless of the network chosen.

There is a separate lifetime maximum of $100 for each Subscriber and each Covered Dependent for occlusal adjustments.

ORTHODONTIC MAXIMUM BENEFIT

Delta Dental's obligation for orthodontic Benefits is limited to the lifetime maximum specified below.

The maximum lifetime orthodontic Benefit is $1,500 for each Subscriber and each Covered Dependent. Dependent children are covered to age 26.

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE:

This Contract provides the following Benefits subject to the Coverage percentage listed for each Benefit and subject to any applicable Deductible. The Coverage and Coinsurance percentages may vary based upon the network membership of the treating Dentist at the time the Dental Procedure is completed. The application of the Deductible, if any, also may vary based upon the network membership of the treating Dentist at the time the Dental Procedure is completed.

For example, if the Coverage percentage shown is "80," that Benefit is 80% of the Maximum Plan Allowance, after satisfaction of any applicable Deductible. In the same example, the Coinsurance (the amount the patient must pay) would be the remaining 20%.

If the Coverage percentage shown is "0", that Benefit is not provided in the Group Contract.

The Benefit Accumulation Period begins on August 1, 2014 ends on July 31, 2015, and thereafter shall be the 12 month period beginning on August 1, 2015.

PPO = Delta Dental PPO Dentist Premier = Delta Dental Premier Dentist NC = Noncontracted Dentist

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
N	N	N	100	100	100	Examinations two times per Benefit Accumulation Period.
N	N	N	100	100	100	Full mouth series x-rays at twenty four month intervals; either individual films, or panoramic film, including bitewings.
N	N	N	100	100	100	Bitewing x-rays no more frequently than two times per Benefit Accumulation Period (limited to a set of four films).
						Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure four times per Benefit Accumulation Period.
N	N	N	100	100	100	Routine prophylaxis.
Y	Y	Y	100	100	100	Periodontal maintenance procedure.
N	N	N	100	100	100	Topical fluoride applications two times per Benefit Accumulation Period for Covered Dependent children to age 19.
N	N	N	100	100	100	Space maintainers for retaining space when a primary tooth is prematurely lost.
N	N	N	100	100	100	Emergency treatment to relieve pain.
N	N	N	100	100	100	Topical application of sealants for Covered Dependents to age 17. Application is limited to the occlusal surface of bicuspids and molars which are free of decay and restorations. Benefits for sealants are limited to one application per tooth once every five years.
Y	Y	Y	100	100	100	Amalgam (silver) restorations.
Y	Y	Y	100	100	100	Composite (tooth colored) restorations.
Y	Y	Y	100	100	100	Stainless steel crowns.
Y	Y	Y	100	100	100	Endodontics including root canal treatment and root canal therapy.
Y	Y	Y	100	100	100	Surgical endodontic treatment.
Y	Y	Y	100	100	100	Non-surgical periodontics including procedures necessary for the treatment of diseases of the gums and bone supporting the teeth – treatment is limited to once per quadrant every 24 months.
Y	Y	Y	100	100	100	Surgical periodontic treatment; treatment is limited to once per quadrant every 36 months.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
Y	Y	Y	100	100	100	Non-surgical extractions.
Y	Y	Y	100	100	100	Oral surgery (cutting procedures) and surgical extractions including pre-operative and post-operative care.
Y	Y	Y	50	50	50	Crowns, inlays, or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns are Benefits on the six front teeth, bicuspids, and upper first molars.
Y	Y	Y	50	50	50	Prosthetics, including fixed bridgework, implants, partial dentures, and complete dentures to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing fixed bridge or partial/complete denture will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns or pontics are Benefits on the six front teeth, bicuspids, and upper first molars. Fixed bridges, partial/complete dentures or implants are provided where chewing function is impaired due to missing teeth. A fixed bridge or implant and implant related procedures may be a Benefit if no more than two teeth are missing in the dental arch in which the bridge is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch. Coverage for initial replacement of teeth is not limited to those lost while a Subscriber or Covered Dependent.
Y	Y	Y	100	100	100	Repairs and adjustments to prosthetic appliances. Denture reline and rebase is a Benefit once in any three year period.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
Y	Y	Y	50	50	50	Covered orthodontic appliances and treatment, related services for orthodontic purposes to include examination, x-rays, photographs, and study models, subject to the orthodontic maximum benefit. Repair and replacement of orthodontic appliances are not covered. Delta Dental calculates all orthodontic treatment schedules according to the following formula: - 25% of the total Maximum Plan Allowance (subject to the Coverage Percentage stated herein and any applicable Deductible) is considered the initial payment to be paid by Delta Dental. - The remainder of the Maximum Plan Allowance is divided by the months of treatment and the resulting amount is paid monthly by Delta Dental (subject to the Coverage Percentage, any applicable Deductible and the orthodontic maximum Benefit stated herein.) If orthodontic treatment is stopped for any reason before it is complete, Delta Dental will suspend all monthly payments. Coverage includes orthodontic treatment in progress. Treatment is in progress if an appliance or banding has been placed and the patient is receiving treatment by the attending orthodontist according to a current treatment plan. Liability for orthodontic treatment in progress shall extend only to the unearned portion of the treatment in progress (that portion occurring after enrollment) and Delta Dental shall be the sole determinant of this unearned amount eligible for coverage. However, there are no Benefits available for Dental Procedures, including orthodontic treatment in progress, after coverage terminates.

OPTIONAL PROCEDURES

Delta Dental will pay the applicable Maximum Plan Allowance for the least expensive Dental Procedure that is adequate to restore the tooth or dental arch to contour and function, but only if that Dental Procedure is a Benefit of this Contract. The Subscriber or Covered Dependent will be responsible for the remainder of the Dentist's fee if a more expensive Dental Procedure is selected. The Coinsurance and Deductible will apply regardless of which Dental Procedure is selected.

SPECIAL CONDITIONS

Consultations are a benefit under this plan.

V6PMCQAJVM05.28.2014

AMENDMENT
TO
HANDBOOK

This Amendment modifies the Group dental benefits afforded by the dental policy with Delta Dental of Wisconsin, Inc. and must be read in conjunction with the Handbook. All terms and conditions of your policy remain in effect, except as modified by this amendment. Please read this amendment carefully.

Effective immediately, the section entitled **Eligibility, Covered Dependents,** in your dental Handbook will be deleted and replaced with the following language:

Covered Dependents. If you are enrolled for family coverage, the following persons may be covered under your Group's Contract as your Dependents:

1. Your lawful spouse

2. Your children (including any children's children until Your child is 18), including step and adopted children and children placed for adoption with you, who are less than 26 years of age.

3. Notwithstanding 1 and 2 above, your adult Dependent children, including step and adopted children and children placed for adoption with you may be covered under this policy if the adult child satisfies all of the following:

   (a) The child is a full-time student, regardless of age; and

   (b) The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher learning; and

   (c) The child re-enrolled as a full-time student within 12 months of returning from active duty.

4. A Dependent child over age 26 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 26, provided a physician's certificate of disability is submitted within six months following the Dependent child's 26th birthday. The Company reserves the right to request proof of continued disability from time to time, but not more often than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

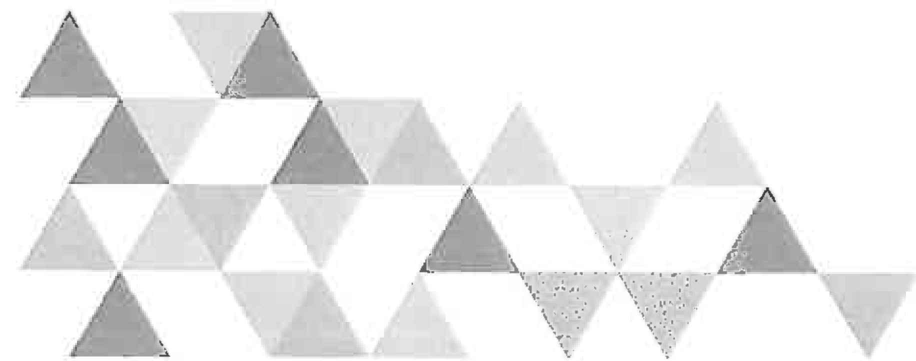
Dependents in military service are not covered by your Group's Contract.

Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. Please see the **Continued Coverage (COBRA)** section of this Dental Benefit Handbook.

THIS AMENDMENT IS PART OF THE HANDBOOK REFERENCED HEREIN AND SHOULD BE KEPT WITH THAT DOCUMENT.

Delta Dental PPO Handbook

Delta Dental Of Wisconsin



Your Choice of Provider — Delta Dental PPO plus Premier℠

Delta Dental PPO plus Premier℠ is Delta Dental's preferred provider organization (PPO). This option offers an added advantage to patients receiving treatment from a Delta Dental PPO Provider.

As a Delta Dental Subscriber, You are free to see any Provider You choose on a treatment by treatment basis – whether or not the Provider is included in our Delta Dental PPO Provider directory. It is important to remember, however, that Your out-of-pocket costs may be lower when You see a Delta Dental PPO Provider.

Delta Dental PPO Provider

Delta Dental PPO Providers have signed a contract with Delta Dental or another member of the Delta Dental Plans Association, agreeing to accept reduced fees for the Dental Procedures they provide. This reduces Your out-of-pocket costs, because You will be responsible only for applicable Deductible amounts and Coinsurance for covered Benefits. You will be responsible for fees for services that are Noncovered Benefits under Your Group's Contract. And because these Providers agree to fees approved by Delta Dental, they receive payment directly from Delta Dental.

Providers Outside the Delta Dental PPO Network:

Delta Dental Premier Providers

Delta Dental Premier Providers have signed a contract with Delta Dental or another member of the Delta Dental Plans Association, agreeing to accept direct payment from Delta Dental. They have also agreed not to charge You any amount that exceeds the Maximum Plan Allowance (MPA). However, You will still be responsible for Deductibles and Coinsurance, and fees for services that are Noncovered Benefits under Your Group's Contract.

The MPA is the total dollar amount allowed under Your Group's Contract for a specific Benefit. The MPA will be reduced by any Deductible and Coinsurance the Subscriber or the Covered Dependent is required to pay.

Noncontracted Providers

If Your Provider has not signed a contract with Delta Dental, claim payments will still be calculated based on the MPA, but they will be sent directly to You rather than to the Provider. You will then need to reimburse Your Provider through his or her usual billing procedure. You will be responsible for any amount in excess of the MPA, as well as any Deductible and Coinsurance, and fees for services that are not Benefits under Your Group's Contract.

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

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

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Welcome

Delta Dental has been selected by Your employer to provide Your Group dental coverage. All of us at Delta Dental are pleased to bring these important Benefits to You and any Dependents You have enrolled for coverage.

It is important for You to read this Dental Benefit Handbook with the Summary of Benefits. The Summary of Benefits lists the specific Benefits of Your Group dental coverage. Together, the Dental Benefit Handbook and the Summary of Benefits comprise Your certificate of insurance.

This Certificate is not the insurance policy: it is evidence of insurance provided under the Contract between Delta Dental and Your employer. All Benefits are paid according to the terms, conditions and provisions of Your Group's Contract. This Certificate describes the essential features of such insurance. This Certificate replaces and supersedes all Certificates, endorsements and riders that we may have previously issued to You prior to the effective date of this Certificate.

The Contract issued to Your employer is the complete document of insurance and governs all claims processing. It will serve as Delta Dental's primary resource when answering questions regarding Your dental claims. You may examine Your Group's Contract any time by contacting Your employer or Delta Dental during normal business hours.

All claims are settled based on a specific methodology. The eligible amount of a claim may be less than the provider's billed charge.

If a clerical error or other administrative mistake occurs, that error will not deprive You of coverage that You would otherwise have had under this policy. A clerical error or other administrative mistake also will not create coverage that does not otherwise exist under this policy.

Definitions

"Benefit Accumulation Period" means the time period that Deductibles and maximum Benefits accumulate. The Benefit Accumulation Period is the time period shown in the Summary of Benefits.

"Benefit" means those Dental Procedures that are covered by Delta Dental under the terms of Your Group's Contract as specified in the Summary of Benefits.

"Certificate" means the Dental Benefit Handbook and Summary of Benefits issued to a Subscriber insured through the Group. The Certificate outlines the Benefits provided by Your Group's Contract.

"Coinsurance" means the percentage of the MPA, after any applicable Deductible is applied, paid by the Subscriber or Covered Dependent for a specific Benefit each time such Benefit is provided under Your Group's Contract.

"Coverage Percentage" means the percentage of the MPA, after any applicable Deductible is applied, paid by Delta Dental for a specific Benefit, as specified in the Summary of Benefits.

"Covered Dependent" means a Dependent who (a) is listed in the documents necessary for coverage under the Contract, (b) has been accepted by Delta Dental for coverage, and (c) for whom the appropriate premium has been paid.

"Deductible" means the specified dollar amount that a Subscriber or Covered Dependent is required to pay each Benefit Accumulation Period before Delta Dental will pay Benefits as specified in the Summary of Benefits.

"Dental Benefit Handbook" means the Group dental insurance handbook and the Summary of Benefits provided by Delta Dental to Subscribers that outlines the dental Benefits available to Subscribers and Covered Dependents.

"Delta Dental" means Delta Dental of Wisconsin, Inc.

"Delta Dental PPO Provider" means:

a. Any Provider who has entered into a Delta Dental of Wisconsin PPO Provider agreement or a PPO Provider agreement with another member of the Delta Dental Plans Association to provide or arrange for the provision of Dental Procedures to Subscribers and Covered Dependents, and who abides by such uniform rules and regulations as prescribed by Delta Dental.

b. Any Provider who is a member or shareholder of a professional dental corporation or other entity that has entered into a corporate Delta Dental of Wisconsin PPO Provider agreement on behalf of its member, shareholder or employee Providers or that has entered into a corporate PPO Provider agreement with another member of the Delta Dental Plans Association on behalf of its member, shareholder or employee Providers.

"Delta Dental Premier Provider" means:

a. Any Provider who has entered into a Delta Dental of Wisconsin Premier Provider agreement or a Premier Provider agreement with another member of the Delta Dental Plans Association to provide or arrange for the provision of Dental Procedures to Subscribers and Covered Dependents, and who abides by such uniform rules and regulations as prescribed by Delta Dental.

b. Any Provider who is a member or shareholder of a professional dental corporation or other entity that has entered into a corporate Delta Dental of Wisconsin Premier Provider agreement on behalf of its member, shareholder or employee Providers or that has entered into a corporate Premier Provider agreement with another member of the Delta Dental Plans Association on behalf of its member, shareholder or employee Providers.

"Dental Procedure" means dental treatment provided to a Subscriber of Covered Dependent by a Provider and reported to Delta Dental using the Code on Dental Procedures and Nomenclature (CDT).

"Dependent" means a person who has satisfied the criteria for eligibility listed in Your Group's Contract.

"Eligible Employee" means an employee or member of the Group who has satisfied the criteria for eligibility to enroll for coverage under Your Group's Contract.

"Grievance" means any dissatisfaction with the administration, claims practices, or provision of services by Delta Dental that is expressed in writing by or on behalf of a Subscriber or Covered Dependent.

"Group" means the employer, association, union or other organization contracting with Delta Dental to provide Benefits to its Eligible Employees or members and their Dependents, if applicable.

"Master Group Contract" or "Contract" means the Group dental insurance policy issued by Delta Dental to the Group in which Delta Dental agrees to provide dental Benefits to the Subscriber or Covered Dependent. The Contract includes the Group application, the Declarations (including the Schedule of Benefits), the Master Group Contract, and any attached addenda, appendixes, endorsements, schedules or riders.

"Maximum Plan Allowance" or **"MPA"** means the total dollar amount allowed for a specific Benefit.

"Noncontracted Provider" means a Provider who is not a Delta Dental PPO Provider or Delta Dental Premier Provider.

"Noncovered Benefits" means those Dental Procedures that are not covered by Delta Dental under the terms of Your Group's Contract.

"PPO" means a preferred provider organization.

"Open Enrollment Period" means an enrollment period during which time any Eligible Employee and/or Dependent may apply to become a Subscriber and/or Covered Dependent, and existing Subscribers may apply to change to another provider network or coverage option, if available, or elect to terminate coverage.

"Premium" means the total monthly fee due for this Contract. The Premium will be based on the Rate and the number of Subscribers.

"Provider" means a person duly licensed under Chapter 447 of the Wisconsin Statutes who acts within the lawful scope of his/her license under Chapter 447 or a person duly licensed in the state or country in which the Dental Procedures are rendered who acts within the lawful scope of his/her license.

"Rate" means the monthly fee required for each Subscriber in accordance with the terms of Your Group's Contract.

"Subscriber" means an Eligible Employee or member of the Group who (a) has completed and signed the

documents necessary for coverage under the Contract, (b) has been accepted by Delta Dental as a Subscriber, and (c) for whom the appropriate Premium has been paid.

"Summary of Benefits" is a listing of the specific Benefits and Benefit limitations for Dental Procedures provided under the terms of Your Group's Contract. The Summary of Benefits is provided as an insert with this Dental Benefit Handbook.

"Urgent Care Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by Delta Dental that requires immediate dental attention. Such grievance must be delivered in writing to Delta Dental. See the Grievance Procedures section of this Handbook.

"You" and **"Your"** means the Subscriber.

Filing Claims

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

Predetermination of Benefits

After an examination, Your Provider may recommend a treatment plan. If the services involve crowns, fixed bridgework, implants, or partial or complete dentures, ask Your Provider to send the treatment plan with images to Delta Dental. The available coverage will be calculated and printed on a Predetermination of Benefits form. Copies of the form will be sent to You and Your Provider.

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

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

Before You schedule dental appointments, You and Your Provider should discuss the amount to be paid by Delta Dental and Your financial obligation for the proposed treatment.

Optional Procedures

Delta Dental will pay the applicable MPA for the least expensive Dental Procedure that is adequate to restore the tooth or dental arch to contour and function, but only if the more expensive Dental Procedure is a Benefit of Your Group's Contract. You will be responsible for either the remainder of the Provider's fee if a more expensive covered Dental Procedure is selected or the entire fee if the more expensive Dental Procedure is not a Benefit. The Coinsurance and Deductible will apply regardless of which Dental Procedure is selected.

Covered Dental Procedures

Only Dental Procedures indicated as Benefits on Your Summary of Benefits insert are covered under Your Group's Contract.

Covered Dental Procedures are subject to the limitations described in the Summary of Benefits and the exclusions outlined in this Dental Benefit Handbook.

Exclusions

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

17. Dental Procedures, services, treatment or supplies to treat injuries or diseases caused by riots or any form of civil disobedience
18. Dental Procedures, services, treatment or supplies to treat injuries sustained while committing a felony or engaging in an illegal occupation
19. Dental Procedures, services, treatment or supplies to treat injuries intentionally inflicted
20. Replacement of lost or stolen dentures or charges for duplicate dentures
21. Dental Procedures, services, treatment or supplies in cases for which, in the professional judgment of the attending Provider, a satisfactory result cannot be obtained
22. Claims not submitted to Delta Dental of Wisconsin within 15 months from the date the procedure was provided
23. Local anesthetic is covered as a part of a Dental Procedure, service or treatment. General anesthetic or intravenous sedation is a Benefit only when billed with covered oral surgery (cutting procedures)
24. If orthodontic procedures are included as Benefits under this Contract, the repair and replacement of orthodontic appliances is not covered

Coordination of Benefits

Applicability

This Coordination of Benefits (COB) provision applies to This Plan when You have health care coverage under more than one Plan. "Plan" and "This Plan" as used in this Coordination of Benefits provision are defined below.

If this COB provision applies, the order of benefit determination rules shall be applied first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

1. Shall not be reduced when under the order of benefit determination rules, This Plan determines its benefits before another Plan, but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the paragraph Effect on the Benefits of This Plan.

Definitions

In addition to the definitions contained in this Certificate, the following definitions apply to this Coordination of Benefits provision:

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

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

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

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid, Title XIX, grants to States for Medical Assistance Programs, or the United States Social Security Plan whose benefits, by law, are excess to those of any private insurance program or other nongovernmental program. Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

"Primary Plan/Secondary Plan" means the order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When Delta Dental is the Secondary Plan, Delta Dental may reduce the Benefits under its Plan only when the sum of the following exceeds the total allowable expense in a Claim Determination Period.

1. The benefits the Secondary Plan would pay for Allowable Expenses in the absence of COB; plus

2. The benefits that would be payable under other applicable Plans for Allowable Expenses in the absence of COB, whether or not claim is made.

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

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

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

Order of Benefit Determination Rules

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

1. The other Plan has rules coordinating its benefits with those of This Plan; and

2. Both those rules and This Plan's rules described in subparagraph 2(b) require that This Plan's Benefits be determined before those of the other Plan.

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

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

2. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (3)(c) below, when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

   a. The benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but

   b. If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent.

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

3. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the Plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

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

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

4. Active/Inactive Employee. The benefits of a Plan which cover a person as an employee who is neither laid off nor retired or as that employee's Dependent are determined before those of a Plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule (4) is ignored.

5. Continuation Coverage.

   a. If a person has continuation coverage under federal or state law and is also covered under another Plan, the following shall determine the order of benefits:

      1. First, the benefits of a Plan covering the employee, member, or Subscriber or Dependent of an employee, member, or Subscriber.

      2. Second, the benefits under the continuation coverage.

   b. If the other Plan does not have the rule described in subparagraph (a), and if as a result, the Plans do not agree on the order of benefits, this paragraph (5) is ignored.

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

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

Effect on the Benefits of This Plan

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

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

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

When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan.

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right of Recovery

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

1. The persons it has paid or for whom it has paid;
2. Insurance companies; or
3. Other organizations.

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

Eligibility

Covered Employee. You are eligible for coverage under Your Group's Contract while You are a regular employee of the Group who averages the number of hours as determined by Your Group's Contract and who has completed any waiting period indicated in the Summary of Benefits.

You may also be covered by Your Group's Contract if You no longer meet these conditions but have elected to continue coverage as described in the Continued Coverage (COBRA) section of this Dental Benefit Handbook.

Covered Dependents. If You are enrolled for family coverage, the following persons may be covered under Your Group's Contract as Your Dependents:

1. Your lawful spouse.
2. Your children including step-children and adopted children and children placed for adoption with You, who are less than 26 years of age.
3. Your children's children until Your child reaches age 18.
4. Notwithstanding 1, 2 and 3 above, Your adult Dependent children, including step-children and adopted children and children placed for adoption with You, may be covered under this policy if the adult child satisfies all of the following:
    a. The child is a full-time student, regardless of age; and
    b. The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher learning; and
    c. The child re-enrolled as a full-time student within 12 months of returning from active duty.
5. A Dependent child over age 26 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 26, provided a physician's certificate of disability is submitted within six months following the Dependent child's 26th birthday. Delta Dental reserves the right to request proof of continued disability from time to time, but not more often than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

If a Subscriber or Covered Dependent is activated while in the Reserve or National Guard, coverage terminates at the time of departure for active duty. Subscribers or Covered Dependents of activated Reserve and National Guard personnel may elect continuation of coverage as described under the Continued Coverage (COBRA) section of this Dental Benefit Handbook. Upon return to civilian status, the Eligible Employee or Covered Person will be reinstated on the date he/she returns to work.

Dependents in military service are not covered by Your Group's Contract.

Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. Please see the Continued Coverage (COBRA) section of this Dental Benefit Handbook.

Effective Dates of Coverage. You are covered by Your Group's Contract beginning on the first day the Contract becomes effective or as determined by Your Group's Contract.

Your Eligible Dependents are covered beginning on the first day You become covered under Your Group's Contract if You elect coverage for them. A newborn child is covered at birth and coverage continues for 60 days. If an additional premium is required to cover the newborn child, You must make written request to Delta Dental and pay the required premium within 60 days of the birth. You may, however, request coverage for a newborn child after the 60-day period but within one year of the birth provided, however, that You pay all required past premiums including an interest rate of 5.5%. If You adopt a child, coverage begins on the day the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first. Changes in enrollment due to birth or adoption must be received by Delta Dental within 60 days of the birth or adoption.

An Eligible Employee who waived coverage because he/she was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The Eligible Employee must apply for such change in coverage within 30 days of the event causing the loss of the other coverage.

Changes in Coverage. You may change your enrollment in this dental plan if You experience a qualifying event such as a change in marital status, the addition of a qualified Dependent or the loss of coverage through Your spouse's plan. The enrollment change will be effective the first day of the month following the qualifying event. Notification of this enrollment change must be received by Delta Dental within 30 days of the qualifying event.

You may change your enrollment without a qualifying event if You contribute toward your premium and if an Open Enrollment Period is offered by the Group. Elective coverage changes can be considered by Delta Dental only at that time.

Notices. Notice to Your employer or Delta Dental will be considered sufficient if mailed to each party's regular office address. Notices to You, as a Subscriber, will be considered sufficient if mailed to Your last known address or the last known address of Your Group. It is the responsibility of Your Group to notify You regarding changes or termination of Your coverage.

Termination of Coverage. Your coverage and that of Your Covered Dependents will cease on the day You or Your Covered Dependents are no longer eligible or the day Your Group's Contract is terminated.

If You or Your Dependents lose eligibility under the Plan, You or Your Dependents may elect to continue coverage as described in the Continued Coverage (COBRA) section of this Dental Benefit Handbook.

All Benefits cease on the day coverage terminates. A Dental Procedure is provided on the date it is completed. Dental Procedures are considered for Benefits if they are provided during the Contract term and a claim is filed within 15 months after the date it is provided.

Continued Coverage

Under Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), If You are part of an employer group of more than 20 employees, You ("Qualified Beneficiaries") are permitted to elect continuation of dental coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

Subscriber:

1. Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. Reduction in hours to less than the minimum required to be an Eligible Employee under this Contract.

Covered Dependents:

1. If You are the Subscriber's spouse:
    a. Death of Subscriber; or
    b. Termination of Subscriber's employment, except for reasons of gross misconduct; or
    c. Reduction of Subscriber's hours to fewer than the minimum required for eligibility for coverage under this Contract; or
    d. Divorce or legal separation from Subscriber; or
    e. Subscriber's Medicare entitlement.
2. If You are the Subscriber's child:
    a. Child ceases to be a Dependent; or
    b. Death of Subscriber; or
    c. Termination of Subscriber's employment, except for reasons of gross misconduct; or
    d. Reduction in Subscriber's hours to less than the minimum required to be eligible as a Subscriber under this Contract; or
    e. Subscriber becomes entitled to Medicare; or
    f. Parents become divorced or legally separated.

Your Group must provide notice to You of Your right to elect COBRA continuation coverage.

If Your coverage is terminated due to divorce, legal separation or cessation of eligibility for coverage, You must provide Your Group notice of such event within 60 days of its occurrence.

An election of continuation coverage must be made within 60 days beginning on the later of the date of the Qualifying Event or the date You receive notice of election rights. The COBRA election by You is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Covered Beneficiary independently elects COBRA continuation coverage.

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

1. 18 months after the Subscriber's employment termination or reduction in hours
2. 29 months after the Qualifying Event for (1) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for (2) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event
3. For Qualified Beneficiaries other than the Subscriber, 36 months after the date of the initial Qualifying Event for all other Qualifying Events
4. The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of Premium. Delta Dental will not reinstate COBRA continuation coverage once terminated for nonpayment of Premium.
5. The date on which the Group ceases to offer this Contract to any of its employees or members
6. The date on which coverage begins under another group dental plan. However, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.
7. The date the Qualified Beneficiary becomes entitled to Medicare benefits

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

In accordance with ERISA Section 602(3), Premium for a qualified disabled person will be 150% of the single, family, or other applicable Rate for the coverage during months 19 through 29 of COBRA continuation coverage. The Premium for all other COBRA continuation coverage will not exceed 100% of the Rate in effect for Your Group during months one through 18, and will not exceed 102% of the Rate in effect for Your Group during months 19 through 36, if applicable.

If You have any questions about continued dental coverage, the human resources department at Your company should be able to help You.

Rights of Recovery (Subrogation)

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

Delta Dental's Liability

In no instance is Delta Dental liable for any conduct, including but not limited to tortious conduct, negligence, or wrongful acts or omissions by any person, including but not limited to Subscribers, Providers, hospitals or hospital employees receiving or providing services. In no instance is Delta Dental liable for services of facilities that, for any reason, are unavailable to You.

Grievance Procedures

How to Contest a Claim Denial

Urgent Care Situations:

Method of Notification. Notice of an Urgent Care Grievance will be accepted by Delta Dental if made by You in writing, in person, or by telephone directed to:

Delta Dental of Wisconsin, Inc.
2801 Hoover Road
P.O. Box 828
Stevens Point, WI 54481-0828
800-236-3712

Resolution Process. If the Urgent Care Grievance cannot be resolved through informal discussions, consultations or conferences during the first 48 hours after Delta Dental's receipt of the Urgent Care Grievance, You may appear before Delta Dental's Grievance committee to present written or oral information with the right to ask questions before the Grievance committee.

Time Limitation for Resolution. An Urgent Care Grievance will be resolved, whether informally or by the Grievance committee, within 72 hours of its receipt by Delta Dental.

All Other Grievance Situations Not Including Urgent Care:

Denial of a Claim for Benefits. If a Subscriber or Covered Dependent makes a claim for Benefits under this Contract and the claim is denied in whole or in part, You or Your Provider will receive written notification within 30 days after Delta Dental receives the claim, unless special circumstances require an extension of time for processing. The claims decision will be sent on a form entitled "Explanation of Benefits."

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

Appealing a Claim Denial. If You have questions about the denial of Your claim for Benefits, You should contact Delta Dental at 800-236-3712. Because most questions about Benefits can be answered informally, Delta Dental encourages You to first try to resolve any problem by talking with Delta Dental. However, You have the right to file an appeal requesting that Delta Dental formally review the Benefits determination.

To file an appeal, fax Your request to 715-343-7616, or mail Your request to:

Delta Dental of Wisconsin, Inc.
2801 Hoover Road, P.O. Box 828
Stevens Point, WI 54481-0828

To file a Grievance or to appeal a Benefits determination, contact Delta Dental's Benefit Services Department at 800-236-3712, fax Your request to 715-343-7616, or mail Your request to:

Delta Dental of Wisconsin, Inc.
2801 Hoover Road, P.O. Box 828
Stevens Point, WI 54481-0828

You should provide the reasons why You disagree with Delta Dental's Benefits determination and include any documentation You believes supports Your claim. You should include Your name, and the employee's name and employee identification number on all supporting documents.

Resolution Procedure. Delta Dental will acknowledge the Grievance or Benefits determination appeal within 5 days of its receipt by Delta Dental. Delta Dental will attempt to resolve the Grievance or Benefits determination appeal through informal discussions, consultations or conferences. In the event that the Grievance or appeal remains unresolved, You have the right to appear before Delta Dental's Grievance committee to present written or oral information and to question the Grievance committee. The committee shall advise You of the time and place of the meeting at least 7 calendar days before the meeting.

If You do not exhaust the appeal procedures described above, and if You file a lawsuit against the Group's dental plan and/or Delta Dental seeking payment of Benefits, the court may not permit You to go forward with Your lawsuit because You failed to utilize Delta Dental's Grievance/claims appeal procedures. No legal action can be brought against Delta Dental more than 3 years after the date of the Grievance committee's final decision on the review of the Benefits determination.

Time Limitations for Resolution. Delta Dental will attempt to resolve all Grievances within 30 calendar days after receipt by Delta Dental. Delta Dental will inform You of its decision in writing. If the Grievance is denied in whole or in part, the notice will include the following information:

1. The specific reason(s) for the denial of the appeal
2. Reference to the specific Contract provision(s) on which the denial is based
3. A statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim
4. A statement describing any voluntary appeal procedures offered by Delta Dental and Your right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA
5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to You upon request
6. If the denial of the appeal was based on a dental necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Contract to Your dental circumstances, or a statement that such explanation will be provided free of charge upon request

If the Grievance cannot be resolved within 30 days from receipt by Delta Dental, Delta Dental will notify You in writing that it intends to extend the period of time for resolution an additional 30 days. The notification will state when resolution may be expected and the reasons for the additional time needed.

All Grievances will be resolved within 60 days from date of receipt by Delta Dental.

Delta Dental's Grievance committee will consist of four persons: a consultant chosen by Delta Dental, a representative of Delta Dental management, Delta Dental's claim administrator, and a policyholder who is not a Delta Dental employee.

You may resolve any grievance through Delta Dental's Grievance procedure outlined above.

Notice of Legal Action

No legal action can be brought against Delta Dental until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or Delta Dental has denied payment, whichever is earlier. If you have any questions, please contact our office:

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

Problems with Your Insurance?

If You are having problems with any insurance company or agent, do not hesitate to contact them to resolve Your problem. You can contact Delta Dental at the following address and phone number:

Delta Dental of Wisconsin
2801 Hoover Road
P.O. Box 828
Stevens Point, WI 54481
800-236-3712

The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To file a complaint, write to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or you can request a complaint form by calling one of these numbers:

800-236-8517 outside Madison
608-266-0103 in Madison

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
www.deltadentalwi.com
800-236-3712

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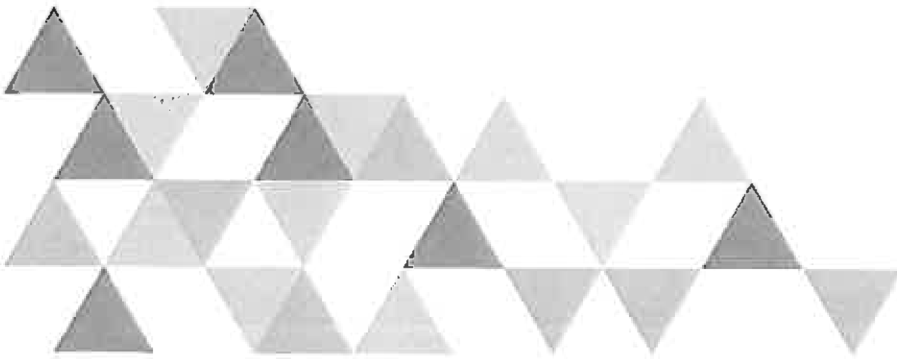
DeltaVision® Handbook

Delta Dental Of Wisconsin



eye Med

DeltaVision Contact Information

Benefits & Information

Contact EyeMed's Customer Care Center for questions concerning benefits, claims payments, and ID cards.

Toll-free: 844-848-7090
EyeMed Hours: Monday-Saturday 7 a.m. to 10 p.m. (CT) Sunday 10 a.m. to 7 p.m. (CT)

Provider Locations

For a list of the most convenient EyeMed Vision Care provider locations, members may visit the Delta Dental website, or the EyeMed Vision Care website, or call EyeMed customer service (number and hours listed above).

Delta Dental: www.deltadentalwi.com/provider-search/vision
EyeMed: www.Eyemedvisioncare.com/locator

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Welcome

DeltaVision is offered through Wyssta Insurance Company, Inc., a wholly-owned subsidiary of Delta Dental of Wisconsin, Inc. Claims processing, claims service and network administration for DeltaVision are handled through an agreement with EyeMed Vision Care, LLC.

Wyssta Insurance Company, Inc. has been selected by Your employer to provide Your group vision coverage. We are pleased to bring these important Benefits to You and any Dependents You have enrolled for coverage.

It is important for You to read this Vision Benefit Handbook with the Summary of Benefits page inserted. The Summary of Benefits lists the specific Benefits of Your group vision coverage. Together, the Vision Benefit Handbook and the Summary of Benefits comprise Your Certificate of insurance.

This Certificate is not the insurance policy. It is merely evidence of insurance provided under the Contract between Wyssta and Your employer. All Benefits are paid according to the terms, conditions, and provisions of Your Group's Contract. This Certificate describes the essential features of such insurance. This Certificate replaces and supersedes all Certificates, endorsements, and riders that we may have previously issued to You prior to the effective date of this Certificate.

The Contract issued to Your employer is the complete document of insurance and governs all claims processing. It will serve as Wyssta's primary resources when answering questions regarding Your vision claims. You may examine Your Group's Contract any time by contacting Your employer or Wyssta during normal business hours.

All claims are settled based on a specific methodology. The eligible amount of a claim may be less than the provider's billed charge.

If a clerical error or other administrative mistake occurs, that error will not deprive You of coverage under the policy that You would otherwise have had. A clerical error or other administrative mistake also will not create coverage that does not otherwise exist under the policy.

Definitions

"Allowance" means the amount or percentage shown in the Summary of Benefits for vision Benefits that Wyssta will pay toward the applicable vision service or product provided.

"Benefit" means those vision Benefits that are covered by Wyssta under the terms of Your Group's Contract as specified in the Summary of Benefits.

"Certificate" means the Vision Benefit Handbook and Summary of Benefits issued to a Subscriber insured through the Group. The Certificate outlines the Benefits provided by Your Group's Contract.

"Contracted Vision Provider" means a vision care provider who has entered into an agreement to provide vision Benefits through Wyssta to Subscribers and Covered Dependents.

"Copayment" means the dollar amount or percentage shown in the Summary of Benefits that You are required to pay directly to a Contracted Vision Provider or a Noncontracted Vision Provider for each service or product received that is a Benefit under the Contract, as specified in the Summary of Benefits. The Copayment is applied to the fee for Benefits that Wyssta contracts with the Contracted Vision Provider to pay or to the Allowance for Benefits, whichever is applicable.

"Covered Dependent" means a Dependent who (a) is listed in the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta for coverage, and (c) for whom the appropriate Premium has been paid.

"Dependent" means a person who has satisfied the criteria for eligibility listed in Your Group's Contract.

"Eligible Employee" means an employee or member of the Group who has satisfied the criteria for eligibility listed in Your Group's Contract.

"Grievance" means any dissatisfaction with the administration, claims practices, or provision of services by Wyssta that is expressed in writing by or on behalf of a Subscriber or Covered Dependent.

"Group" means the employer, association, union or other organization contracting with Wyssta to provide Benefits to its Eligible Employees or members and their Dependents, if applicable.

"Master Group Contract" or **"Contract"** means the group vision insurance policy issued by Wyssta to the Group in which Wyssta agrees to provide vision Benefits to Subscribers and Covered Dependents. The Contract includes the group application, the Declarations, the Master Group Contract, and any attached addenda, appendixes, endorsements, schedules or riders.

"Noncontracted Vision Provider" means a vision care provider who has not entered into an agreement to provide vision Benefits through Wyssta to Subscribers and Covered Dependents.

"Open Enrollment Period" means an enrollment period during which time any Eligible Employees and/or Dependents may apply to become a Subscriber and/or Covered Dependent, and existing Subscribers may apply to change to another provider network or coverage option, if available, or elect to terminate coverage.

"Premium" means the total monthly fee due for this Contract. The Premium will be based on the Rate and the number of Subscribers.

"Rate" means the monthly fee required for each Subscriber in accordance with the terms of Your Group's Contract.

"Subscriber" means an Eligible Employee or member of the Group who (a) has completed and signed the documents necessary for coverage under the Contract, (b) has been accepted by Wyssta as a Subscriber, and (c) for whom the appropriate Premium has been paid.

"Summary of Benefits" is a listing of the specific Benefits and Benefit limitations for vision Benefits provided under the terms of Your Group's Contract. The Summary of Benefits is provided as an insert with the Vision Benefit handbook.

"Urgent Care Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by Wyssta that requires immediate attention. Such Grievance must be delivered in writing to Wyssta. See the Grievance Procedures section of this Vision Benefit Handbook.

"Wyssta" means Wyssta Insurance Company, Inc.

"You" and **"Your"** means the Subscriber.

Filing Claims

Using a Contracted Vision Provider

Follow these simple steps to access Your network vision Benefits:

1. Present Your employee identification card to Your provider or provide Your name, address and date of birth
2. Your provider will confirm Your eligibility as a DeltaVision member
3. You will receive services and Your provider will calculate any out-of- pocket expenses after the Benefit has been applied. You are responsible for any out-of- pocket expenses at the time of service
4. Your provider takes care of the rest.

Using a Noncontracted Vision Provider

When You visit a non-network vision provider You may file a claim as follows:

1. Pay in full for services and materials to Your Noncontracted Vision Provider at the time of service
2. Request an itemized receipt from Your provider
3. Contact EyeMed via phone or website to obtain a claim form
4. Submit the total claim on the EyeMed claim form, attaching the itemized receipt
5. You will be reimbursed by EyeMed at non-network DeltaVision plan Benefit levels

Applicability of Allowances

Vision Benefit Allowances are available for a single application toward the cost of vision services and materials covered under this plan. Any Allowance balance remaining may not be applied to any other services.

Covered Vision Procedures

Only vision procedures indicated as Benefits on Your Summary of Benefits insert are covered under Your Group's Contract.

Covered vision Benefits are subject to the limitations described in the Summary of Benefits insert and the exclusions outlined in this Vision Benefit Handbook. Wyssta will pay up to the Allowance shown in the Summary of Benefits for vision Benefits and You will be responsible for any remaining amount.

You will also be responsible for any vision care products and services that are not Benefits under the Contract regardless of whether the vision care services were provided by a Contracted Vision Provider or a Noncontracted Vision Provider.

Exclusions

1. Any vision procedures, supplies, treatment, or any other services, as applicable, provided or commenced prior to the effective date of the Subscriber's or Covered Dependent's coverage under the Contract
2. Any vision procedures, supplies, treatment, or any other services to treat injuries or conditions compensable under worker's compensation or employer's liability laws
3. Charges for completion of forms
4. Charges for consultation
5. Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
6. Aniseikonic lenses
7. Medical and/or surgical treatment of the eye, eyes, or supporting structures
8. Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this Contract
9. Plano nonprescription lenses and nonprescription sunglasses
10. Benefits combined with any discount, promotional offering, or other group benefit plans

11. Lost or broken materials

12. Two pairs of glasses in lieu of bifocals (does not apply to Primary-Plus plan members or Preferred-Plus plan members)

13. Any vision procedures, supplies, treatment, or any other services, as applicable, except as provided in the Summary of Benefits

14. Vision procedures not specifically covered under this Contract

Eligibility

Covered Employee

You are eligible for coverage under Your Group's Contract while You are a regular employee of the Group who averages the number of hours as determined by the Group's Contract and who has completed any waiting period indicated on the Summary of Benefits.

You may also be covered by Your Group's Contract if You no longer meet these conditions but have elected to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Covered Dependents

If You are enrolled for family coverage, the following persons may be covered under Your Group's Contract as Your Dependents:

1. Your lawful spouse

2. Your children including step and adopted children and children placed for adoption with You, who are less than 26 years of age

3. Your children's children until Your child reaches age 18

4. Notwithstanding 1, 2 and 3 above, Your adult Dependent children, including step-children and adopted children and children placed for adoption with You may be covered under this policy if the adult child satisfied all of the following:

    a. The child is a full-time student, regardless of age; and

    b. The child was under 26 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full time basis, an institution of higher learning; and

    c. The child re-enrolled as a full-time student within 12 months of returning from active duty.

5. A Dependent child over age 26 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 26, provided a physician's certificate of disability is submitted within six months following

the Dependent child's 26th birthday. Wyssta reserves the right to request proof of continued disability from time to time, but not more than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

Dependents in military service are not covered by Your Group's Contract.

Dependents no longer meeting the above requirements because of divorce or separation from an Eligible Employee, or the end of a child's dependency status may elect to continue coverage. Please see the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Effective Dates of Coverage

You are covered by Your Group's Contract beginning on the first day the Contract becomes effective or as determined by Your Group's Contract.

Your Eligible Dependents are covered beginning on the first day You become covered under Your Group's Contract If You elect coverage for them. A newborn is covered at birth and coverage continues for 60 days. If an additional Premium is required to cover the newborn, You must make written request to Wyssta and pay the required Premium within 60 days of the birth. You may, however, request coverage for a newborn after the 60-day period but within one year of the birth provided, however, that You pay any required Premium including an interest rate of 5.5%. If You adopt a child, coverage begins on the day the child is adopted, placed for adoption, or on the day of the final order granting adoption, whichever comes first. Changes in enrollment due to birth or adoption must be received by Wyssta within 60 days of the birth or adoption.

An Eligible Employee who waived coverage because he/she was covered under other insurance may elect coverage to be effective on the first day of the month following the loss of such other coverage. The Eligible Employee must apply for such change in coverage within 30 days of the event causing the loss of the other coverage.

Changes in Coverage

You may change Your enrollment in this vision plan if You experience a qualifying event such as a change in marital status, the acquisition of a Dependent, or the loss of coverage through your spouse's plan. The enrollment change will be effective the first of the month following the qualifying event. Notification of this enrollment change must be received by Wyssta within 30 days of the qualifying event.

You may change Your enrollment without a qualifying event if You contribute toward Your Premium and if an Open Enrollment Period is offered by the Group. Elective coverage changes can be considered by Wyssta only at that time.

Notices

Notice to Your employer or Wyssta will be considered sufficient if mailed to each party's regular office address. Notices to You, as a Subscriber, will be considered sufficient if mailed to Your last known address or the last known address of Your Group. It is the responsibility of Your Group to notify You regarding changes or termination of Your coverage.

Termination of Coverage

Your coverage and that of Your Covered Dependents ceases on the day You or Your Covered Dependents are no longer eligible or the day Your Group's Contract is terminated.

If You or Your Dependents lose eligibility under the plan, You or Your Dependents may elect to continue coverage as described in the Continued Coverage (COBRA) section of this Vision Benefit Handbook.

Continued Coverage

Under Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), if You are part of an employer group of more than 20 employees, You ("Qualified Beneficiaries") are permitted to elect continuation of vision coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

Subscriber:

1. Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or
2. Reduction in hours to less than the minimum required to be an Eligible Employee under this Contract.

Covered Dependents

1. If you are the Subscriber's spouse:
   a. Death of Subscriber; or
   b. Termination of Subscriber's employment, except for reasons of gross misconduct; or
   c. Reduction of Subscriber's hours to fewer than the minimum required for eligibility for coverage under this Contract; or
   d. Divorce or legal separation from Subscriber; or
   e. Subscriber's Medicare entitlement.
2. If you are the Subscriber's child:
   a. Child ceases to be a Dependent; or
   b. Death of Subscriber; or
   c. Termination of Subscriber's employment, except for reasons of gross misconduct; or
   d. Reduction in Subscriber's hours to less than the minimum required to be eligible as a Subscriber under this Contract; or
   e. Subscriber becomes entitled to Medicare; or
   f. Parents become divorced or legally separated.

Your Group must provide notice to You of Your right to elect COBRA continuation coverage.

If Your coverage is terminated due to divorce, legal separation or cessation of eligibility for coverage, You must provide Your Group notice of such event within 60 days of its occurrence.

An election of continuation coverage must be made within 60 days beginning on the later of the date of Qualifying Event or the day You receive notice of election rights. The COBRA election by You is deemed an election by all others who would lose coverage as a result of the same Qualifying Event unless otherwise specified in the election or the Covered Beneficiary independently elects COBRA continuation coverage.

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

1. 18 months after the Subscriber's employment termination or reduction in hours

2. 29 months after the Qualifying Event for (a) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for (b) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event

3. For Qualified Beneficiaries other than the Subscriber, 36 months after the date of the initial Qualifying Event for all other Qualifying Events

4. The date on which the Qualified Beneficiary receiving continuation in coverage fails to make a timely payment of Premium. Wyssta will not reinstate COBRA continuation coverage once terminated for nonpayment of Premium

5. The date on which the Group ceases to offer this Contract to any of its employees or members

6. The date on which coverage begins under another vision plan. However a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.

7. The date the Qualified Beneficiary becomes entitled to Medicare benefits

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

In accordance with ERISA Section 602(3), Premium for a qualified disabled person will be 150% of the single, family, or other applicable Rate for the coverage during months 19 through 29 of COBRA continuation coverage. The Premium for all other COBRA continuation coverage will not exceed 100% of the Rate in effect for the Group during months one through 18, and will not exceed 102% of the Rate in effect for Your Group during months 19 through 36, if applicable.

If You have any questions about continued vision coverage, the human resources department at Your company should be able to assist You.

Wyssta's Liability

In no instance is Wyssta liable for any conduct, including but not limited to tortious conduct, negligence, or wrongful acts or omissions by any service provider or other professional practitioner or their agents or employees in the provision or receipt of health care. In no instance is Wyssta liable for services of facilities that, for any reason, are unavailable to You.

Grievance Procedures

How to Contest a Claim Denial

Urgent Care Situations:

Method of Notification. Notice of an Urgent Care Grievance will be accepted by Wyssta if made by You in writing, in person, or by telephone directed to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
888-838-4875

Resolution Process. If the Urgent Care Grievance cannot be resolved through informal discussions, consultations or conferences during the first 48 hours after Wyssta's receipt of the Urgent Care Grievance, You may appear before Wyssta's Grievance committee to present written or oral information with the right to ask questions before the Grievance committee.

Time Limitation for Resolution. An Urgent Care Grievance will be resolved, whether informally or by the Grievance committee, within 72 hours of its receipt by Wyssta.

All Other Grievance Situations Not Including Urgent Care:

Denial of a Claim for Benefits. If a Subscriber or Covered Dependent makes a claim for Benefits under this Contract and the claim is denied in whole or in part, You will receive written notification within 30 days after Wyssta receives the claim, unless special circumstances require an extension of time for processing. The claims decision will be sent on a form entitled "Explanation of Benefits".

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

Appealing a Claim Denial. If You have questions about the denial of Your claim for Benefits, You should contact EyeMed Vision Care, LLC at 866-723-0513. Because most questions about Benefits can be answered informally,

Wyssta encourages You to first try to resolve any problem by talking with EyeMed. However, You have the right to file an appeal requesting that Wyssta formally review the Benefits determination.

To file a Grievance or to appeal a Benefits determination, contact Wyssta's Benefit Services Department at 888-838-4875 or mail Your request to:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481

You should provide the reasons why You disagree with Wyssta's Benefits determination and include any documentation you believe supports Your claim. You should include Your name, and the employee's name and employee's member number on all supporting documents.

Resolution Procedure. Wyssta will acknowledge the Grievance or Benefits determination appeal within 5 days of its receipt by Wyssta. Wyssta will attempt to resolve the Grievance or Benefits determination appeal through informal discussions, consultations or conferences. In the event that the Grievance or appeal remains unresolved, You have the right to appear before Wyssta's Grievance committee to present written or oral information and to question the Grievance committee. The committee shall advise You of the time and place of the meeting at least 7 calendar days before the meeting.

If You do not exhaust the appeal procedures described above, and if You file a lawsuit against the Group's vision plan and/or Wyssta seeking payment of Benefits, the court may not permit You to go forward with Your lawsuit because You failed to utilize Wyssta's Grievance/claims appeal procedures. No legal action can be brought against Wyssta more than 3 years after the date of the Grievance committee's final decision on the review of the Benefits determination.

Time Limitations for Resolution. Wyssta will attempt to resolve all Grievances within 30 calendar days after receipt by Wyssta. Wyssta will inform You of its decision in writing. If the Grievance is denied in whole or in part, the notice will include the following information:

1. The specific reasons(s) for the denial of the appeal
2. The reference to the specific Contract provision(s) on which the denial is based
3. A statement that You are entitled to receive, upon request, and free of charge, reasonable access to, and copies of all documents, records, and information relevant to the claimant's claim
4. A statement describing any voluntary appeal procedures offered by Wyssta and the claimant's right to obtain information about such procedures, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA
5. If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to You upon request
6. If the denial of the appeal was based on necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Contract to Your circumstances, or a statement that such explanation will be provided free of charge upon request

If the Grievance cannot be resolved within 30 days from receipt by Wyssta, Wyssta will notify You in writing that it intends to extend the period of time for resolution an additional 30 days. The notification will state when resolution may be expected and the reasons for the additional time needed.

All Grievances will be resolved within 60 days from the date of receipt by Wyssta.

Wyssta's Grievance committee will consist of four persons: a consultant chosen by Wyssta, a representative of Wyssta management, Wyssta's claim administrator, and a Subscriber in a Wyssta plan who is not a Wyssta employee.

You may resolve any Grievance through Wyssta's Grievance procedure outlined above.

Notice of Legal Action

No legal action can be brought against Wyssta until at least 60 days after proof of loss has been furnished as required by the policy or such proof of loss has been waived, or Wyssta has denied payment, whichever is earlier.

If you have any questions, please contact our office:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
888-838-4875 or 715-344-6087

Problems with Your Insurance?

If You are having problems with an insurance company or agent, do not hesitate to contact them to resolve Your problem. You can contact Wyssta at the following address and phone number:

Wyssta Insurance Company, Inc.
P.O. Box 85
Stevens Point, WI 54481
888-838-4875

The Office of the Commissioner of Insurance is a state agency that enforces Wisconsin's insurance laws. To file a complaint, write to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

Or you can request a complaint form by calling one of these numbers:

800-236-8517 outside Madison
608-266-0103 in Madison

Delta Dental of Wisconsin
P.O. Box 828
Stevens Point, WI 54481
www.deltadentalwi.com
800-236-3712

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