



For Eligible Employees

of

**UNIVERSITY OF
WISCONSIN BOARD OF
REGENTS**

Effective January 1, 2010

**SUPPLEMENTAL
PLAN**

Notice to Plan Participants

This insurance plan has been authorized by the Group Insurance Board for the purpose of permitting premium collection through payroll deductions under the authority granted by § 40.03 (6) (b) and pursuant to § 20.921 (1) (a) 3 State Statute. The criteria the Board uses involves meeting several requirements which include, but are not limited to: documentation of financial stability, demonstration of a reasonable ratio of claims paid to the premium level, authority to conduct business in the State of Wisconsin, agreeing to conditions for the rate-making process and other administrative conditions. DETF staff and the Board's actuary review proposals for participation prior to Board approval. However, the Board does not require competitive bids nor a benefit comparison with similar products from other vendors. **Authorization for payroll deduction should not be construed as an endorsement of this plan by either the Group Insurance Board or the Department of Employee Trust Funds.**

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SUPPLEMENTAL PLAN BENEFIT HANDBOOK

DentalBlue settles claims based upon varying methodologies, which may be less than the provider's billed charge. Please see page 49 in the General Provisions section of this Booklet for more details.

Please direct Enrollment Information to:

ANTHEM BCBS
P. O. Box 9274
Oxnard, CA 93031-9274
1-866-589-0582

Please Direct Correspondence, Claims & Grievances To:

ANTHEM BCBS
Attn: Appeals Department
P.O. Box 9155
Oxnard, CA 93031-9155

Blue Cross Blue Shield
of Wisconsin dba Anthem Blue Cross and Blue Shield
N17 W24340 Riverwood Drive
Waukesha, WI 53188

HOW YOUR PLAN WORKS

READ THIS BOOKLET CAREFULLY BEFORE YOU RECEIVE CARE!

This Booklet will become an important tool in helping You interpret the benefits You now enjoy as a DentalBlue Member. We have tried to outline Your dental coverage in a straightforward manner, using plain language.

Though we have tried to make this Booklet as detailed as possible, You may still have questions about Your coverage or membership. When you have questions You may call or write DentalBlue Customer Service at the address listed in the front of the Booklet.

We have contracted with dental providers and facilities who have agreed to provide Our Members with dental services. The dental professionals are not employees, agents, or representatives of Us nor do We have an ownership interest in any dental facility at this time. Your dental provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a covered benefit under your policy.

Identification Cards

We give You an Identification Card. It ends most red tape and claim procedures. Show Your card at Your Dentist's office when requesting services.

Making An Appointment

When You need treatment, call ahead to make an appointment. When You call, have Your ID card handy. If You must cancel an appointment, please do so at least 24 hours in advance or as soon as possible. You may be charged if You fail to cancel an appointment.

Changes in Enrollment

Contact your Employer to obtain a form for changes in births, adoption, marriages, divorce, separation, deaths, marriage of dependents, and military induction.

Questions

For any additional questions or concerns, please contact DentalBlue Customer Service at the number listed in the front of this booklet.

DENTALBLUE SUPPLEMENTAL PLAN

Your employer has purchased the DentalBlue Supplemental Plan as Your dental benefit plan. The plan is a product of Blue Cross Blue Shield of Wisconsin.

What is Covered by the DentalBlue Supplemental Plan

The plan offers Members a comprehensive package of dental benefits. The services listed in the following categories are DentalBlue Supplemental Plan Covered Services:

- Basic Services
- Major Services

For a complete list of DentalBlue Supplemental Plan Covered Services covered in each of the above categories, please refer to the Covered Services section.

Where You Can Obtain DentalBlue Supplemental Plan Covered Services

The DentalBlue Supplemental Plan is designed to provide you with flexibility in choosing a Dentist.

Change in Preferred Provider status

Be sure to call ahead when planning to visit your Dentist to ensure that he or she is still part of our network. If the Dentist has left the network, benefits will be calculated on the Non-Preferred Provider basis.

How You Pay Your Dentist for DentalBlue Supplemental Plan Covered Services

As you have the choice to see any Dentist when receiving benefits under the DentalBlue Supplemental Plan, You or Your Dentist will be required to file a claim form with Us for payment of benefits under the DentalBlue Supplemental Plan. Claim forms can be submitted by You or Your Dentist to the address that is indicated on the front of the booklet.

As indicated in Your Schedule of Benefits, You may have out-of-pocket costs in the form of Deductible, Copay, Coinsurance, and Maximum Benefits depending on the DentalBlue Supplemental Plan Covered Services You receive from Your Dentist.

Your Dentist will provide You with a Treatment Plan that indicates Your out-of-pocket costs. You will make payment directly to Your Dentist according to the terms and methods of payment defined by him or her.

Pre-Certification of DentalBlue Supplemental Plan Covered Services

Pre-certification is required for any course of treatment of \$300 or more. You or Your Dentist should send a written Treatment Plan to Us, and We will pre-certify the benefits available. Where we gave prior pre-certification of benefits for a treatment or service, benefits will be paid as long as the Member's coverage is in force and if the pre-certification has not expired at the time such treatment or service is provided.

ADDITIONAL DENTAL BENEFIT

In addition to the DentalBlue Supplemental Plan, Your employer has also selected the following DentalBlue benefit plan option:

- Basic Orthodontic Plan

This plan is a product of Blue Cross Blue Shield of Wisconsin.

THE BASIC ORTHODONTIC PLAN

What is Covered by the Basic Orthodontic Plan

The Basic Orthodontic Plan offers a discount for many services performed in conjunction with orthodontic treatment. The following categories of services are included in the Basic Orthodontic Plan:

- Diagnostic Orthodontic Services
- Orthodontic Treatment Services

For a complete list of Orthodontic Plan Covered Services covered in each of the above categories, please refer to the Covered Services section.

Where You Can Receive Basic Orthodontic Plan Covered Services

You must receive Basic Orthodontic Plan Covered Services from a Participating Orthodontist. Participating Orthodontists provide You with a discount on Orthodontic Plan Covered Services.

How to Pay Your Participating Orthodontist for Basic Orthodontic Plan Covered Services

There are no claim forms or pre-certifications required to receive benefits under the Basic Orthodontic Plan.

As indicated in the Schedule of Benefits, You may have out-of-pocket costs in the form of Copayment, Coinsurance, and Maximum Benefits depending on the Basic Orthodontic Plan Covered Services You receive from Your Participating Orthodontist.

Your Participating Orthodontist will provide You with a treatment plan that indicates Your out-of-pocket costs. You will make payment directly to Your Participating Orthodontist according to the terms and methods of payment defined by him or her.

ELIGIBILITY

In this Section, “You” and “Your” refer only to the Subscriber.

SUBSCRIBER ELIGIBILITY

The Supplemental Plan is designed to provide dental coverage if your medical plan has a dental benefit AND you want additional comprehensive benefits.

To be eligible for coverage, Participants must be University of Wisconsin System non-represented classified employees, faculty, academic staff, graduate assistants and employees in-training eligible to enroll, with immediate or future state share contribution, in the State of Wisconsin group health insurance program and not collecting a Wisconsin State Retirement annuity benefit.

Employees eligible for graduate assistant benefits but electing not to participate in this program upon initial eligibility will have a second enrollment opportunity if they later become eligible for a Wisconsin Retirement System (WRS) eligible position and there is no break in service of 30 days or more.

Upon retirement, you may keep coverage in force by paying premiums directly to DentalBlue on a timely basis.

The Supplemental Plan requires that YOU are enrolled in a medical plan providing, at a minimum, diagnostic and preventative dental coverage.

DEPENDENT ELIGIBILITY

A Dependent means and includes:

1. The legal spouse of the Subscriber
2. Your or Your insured spouse’s unmarried children who are unable to provide their own support. This includes legally adopted children, and children for whom You or Your insured spouse is the legal guardian. A Dependent child ceases to be an eligible Dependent:

- a. At the end of the calendar month he or she marries. A child who marries ceases to be eligible and cannot regain Dependent eligibility at a later date;
- b. At the end of the month he or she reaches age 27 if the child is not eligible for coverage under a group health benefit plan offered by the child's employer.

Continued coverage will only be available if the premium contribution charged by the child's employer is greater than the premium charged under this Booklet for the Dependent.

Reaching the limiting age does not end the coverage of a Dependent child who is both:

- 1) Incapable of self-sustaining employment due to mental retardation or physical handicap and chiefly dependent on You or Your spouse for support and maintenance. The incapacity and dependency must begin while the child is insured under this Contract. You must provide Us proof of the incapacity and dependency within 31 days of the child's reaching the limiting age. Then You must provide proof as often as We require. This will not be more often than once a year after the 2 year period following the child's reaching the limiting age. You must provide the proof at no cost to Us.
- 2) Called to active duty in the National Guard or in a reserve component of the United States armed forces prior to age 27 and is currently a full-time student, regardless of age. The Dependent child cannot be eligible for coverage under his/her employer's group health plan unless the premium for that coverage is greater than the premium charged for a Dependent under this Booklet. Coverage will end when the child ceases to be a full-time student, marries, or becomes eligible for a group health plan for which the premium is less than the premium charged a Dependent under this Booklet.

A Dependent also includes Your Dependent child's children (Your grandchildren) until Your Dependent child reaches age 18.

COVERAGE OF DEPENDENT STUDENTS ON MEDICAL LEAVE

If, while covered under this Booklet, a Dependent student needs to reduce his/her course load or leave school due to a Medically Necessary leave of absence, the Dependent student may be eligible to continue coverage under this Booklet.

We may require documentation of the Medical Necessity of the leave of absence from the Dependent's attending Physician. The date on which the Dependent ceases to be a full-time student due to the Medically Necessary leave of absence shall be the date on which the continuation of coverage begins.

Coverage will continue until any of the following occurs:

1. We are advised that the Dependent does not intend to return to school full-time.
2. The Dependent becomes employed full-time.
3. The Dependent obtains other health care coverage.
4. The Dependent marries and is eligible for coverage under his or her spouse's health care coverage.
5. Coverage of the Member through whom the person has Dependent coverage under the Booklet is discontinued or not renewed.
6. One year has elapsed since the Dependent's continuation of coverage began and the Dependent has not returned to school full-time.

APPLICATION & EFFECTIVE DATE:

1. Subscribers

Eligible Subscribers may apply for coverage at the times listed below.

- a. Within 30 days of initial eligibility.

Coverage for a Subscriber who applies within 30 days of initial eligibility is effective the first of month following:

- 1) the date he or she completes any Probationary Period;
and
- 2) the date We receive the completed application.

b. During an Open Enrollment Period.

Coverage for a Subscriber who applies during an open enrollment period is effective the first day following the date agreed upon by Us and the Group.

c. More than 30 days after he or she first becomes eligible for coverage if he or she applies for coverage within 30 days of termination or exhaustion of other coverage (or within 60 days after Medicaid coverage ends).

Coverage for a Subscriber who applies within 30 days of termination or exhaustion of other coverage (or within 60 days after Medicaid coverage ends) is effective first of month following Our receipt of the completed application.

d. Within 60 days of marriage, birth of a child, or placement for adoption.

Coverage for a Subscriber who applies within 60 days of marriage, birth of a child, or placement for adoption is effective on the date of the marriage, or birth, or placement for adoption.

2. Dependents

Eligible Dependents may apply for coverage at the times listed below.

a. Within 30 days of the Subscriber's initial eligibility.

Coverage for a Dependent who applies within 30 days of the Subscriber's initial eligibility is effective the first of month following the date the Subscriber completes any Probationary Period.

b. During an Open Enrollment Period.

Coverage for a Dependent who applies during an Open Enrollment period is effective the first day following the date agreed upon by Us and the Group.

c. More than 30 days after he or she first becomes eligible for coverage if he or she applies for this coverage within 30 days of losing eligibility under another dental plan (or within 60 days after Medicaid coverage ends).

Coverage for a Dependent who applies within 30 days of termination or exhaustion of other coverage (or within 60 days after Medicaid coverage ends) is effective first of month following Our receipt of the completed application.

- d. Within 30 days of the Subscriber's marriage
Coverage for a Dependent who applies within 30 days of the Subscriber's marriage is effective on the date of the marriage.
- e. Following the birth of a Dependent.
 - 1) Coverage for a Dependent who applies within 60 days of the birth of a Dependent is effective on the date of birth.
 - 2) For newborns, if Family Coverage is already in force, coverage for a newborn Dependent is effective on the date of birth. If additional premium is required for the newborn Dependent, coverage begins on the date of birth if the Subscriber notifies Us of the birth and pays the additional premium within one year of the birth.
- f. Following Adoption or Placement for Adoption of a Dependent
 - 1) Coverage for a Dependent who applies within 60 days of an adoption or placement for adoption of a Dependent is effective on the date of the adoption or placement for adoption.
 - 2) For Adopted Dependents when Family coverage is already in force, if the adopted Dependent applies within sixty (60) days, coverage begins on the date the Dependent is adopted by or placed for adoption with the Subscriber.
 - If additional premium is required for the adopted Dependent, coverage begins on the date of the adoption or placement for adoption if the adopted Dependent applies for coverage and pays any additional premium within sixty (60) days of the adoption or placement for adoption.

- g. Following the issuance of a court order requiring Family Coverage.

Coverage for a Dependent who applies after the issuance of a court order requiring Family Coverage is effective on the first of the month following the presentation of a valid court order requiring Family Coverage to Us.

- 3. You are not covered by the Contract until Your Effective Date. We will notify You of Your Effective Date when We send Your Identification Card.
- 4. Unless the Benefit Provisions state otherwise, on the day Your coverage is to become effective,
 - a. You must be actively at Work. A day of vacation or a holiday is considered Active Work if You are able to do Active Work on that day. If You are not Actively at Work, Your Effective Date is the day You return to Active Work.
 - b. Your Dependent cannot be an Inpatient on his or her Effective Date. The Effective Date is deferred until the first date he or she is not an Inpatient, except as otherwise noted in this Contract. This does not apply to a newborn child.
- 5. If You apply for Your coverage and Your dependent's coverage, You and Your dependents will have the same Effective Date. A dependent's Effective Date cannot be before Your Effective Date unless:
 - a. you are totally disabled on the effective date of your plan; and
 - b. you were validly covered by the group's prior benefit plan on the date it terminated.

Then, your dependent's effective date is the day your coverage would have been effective if you were not totally disabled.

BADGERCARE

If the Wisconsin Department of Health and Family Services agrees to purchase coverage under this Booklet for you in lieu of enrolling you in the Medical Assistance Program (under s.49.472, Wis. Stat), Badger Care (under s. 49.665, Wis. Stat.), or BadgerCare Plus (under s. 49.471, Wis. Stat.), you will have 60 days from the date of that determination to apply for this coverage. If we receive your completed application within 60 days, We will enroll you on the first of the month following Our receipt of the application

INDIVIDUAL REINSTATEMENTS

If coverage ends because Your employment terminates, the coverage may be reinstated when You return to Active Work.

If You return to Active Work within 90 days of Your termination date, coverage is effective on the date of return. Any waiting periods apply only to the extent they applied before termination. The benefits We reinstate are the benefits that You and Your Dependents would have received if coverage had been continuous. You must pay any premium required of You.

If You return to Active Work more than (90 days) after Your termination date, We consider You to be a new eligible person. The Application and Effective Date provisions then apply.

COURT-ORDERED COVERAGE

If a court orders a Member to provide coverage for dental expenses for a child of the Member and the Member is eligible for Family Coverage under this Contract, We:

1. Provide Family Coverage under the Contract for the Member's child, if eligible for coverage, without regard to any Enrollment Period restrictions that may apply under the Contract;
2. Provide Family Coverage under the Contract for the Member's child, if eligible for coverage, upon application by the Member, the child's other parent, or the Department of Health and Family Services or the county designee under s. 59.07 (97); and

3. After the child is covered under the Contract, and as long as the Member is eligible for Family Coverage under the Contract, continue to provide coverage for the child unless We receive satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable dental coverage.

If We provide coverage under a Contract for a child of a Member who is not the custodial parent of the child, We shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's enrollment;
2. Permit the custodial parent of the child, a dental Provider that provides services to the child, or the Department of Health and Family Services to submit claims for Benefits without the approval of the parent who is the Member; and
3. Pay claims directly to the dental care Provider, the custodial parent of the child, or the Department of Health and Family Services as appropriate.

NOTE: Please see the Application and Effective Date section for further information concerning the Effective Date for court-ordered coverage.

GENERAL DEFINITIONS

When used and capitalized in this booklet, these terms have the following definitions:

ACTIVELY AT WORK/ACTIVE WORK means You are regularly performing the duties of Your principal occupation for Your regularly scheduled number of hours at Your usual place of business.

BOOKLET means a document that summarizes Contract benefits.

CALENDAR YEAR means January 1 through December 31 of each year.

CHARGE means the negotiated rate We have established by agreement with the Provider, if any, or, if there is no negotiated rate, the Usual, Customary, and Reasonable Amount (UCR Rate) for Covered Services. Where the negotiated rate is based on capitation, the charge is always the UCR Rate which would have otherwise applied to that Covered Service. No agreement as to the rate, fee, or cost between You and a person, firm or corporation providing or rendering services or items shall increase Our liability to an amount more than the UCR rate.

COINSURANCE means a portion of the Charge for Covered Services for which You are responsible. Coinsurance is based on the lesser of the negotiated rate We have established with the Provider, or the UCR Rate for the Covered Service, as applicable. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

COINSURANCE MAXIMUM means the most any Member or a Family must pay in Coinsurance in a Calendar Year. We do not accumulate Copayments or expenses paid toward the Deductible when calculating the Coinsurance Maximum. After You have reached the Coinsurance Maximum, We pay 100% of Charges for Covered Services up to the maximum benefit.

COMPLAINT means any dissatisfaction expressed to Us by You or on Your behalf with Us or Our contracted Providers.

CONTRACT means the Group Application, the Group Master Contract, the member handbook, member applications, and amendments thereto.

CONTRACT EFFECTIVE DATE means the date on which coverage under the Contract begins for the Group. It is shown on the Contract's face page.

CONTRACT TERMINATION DATE means the date on which the Contract terminates.

COVERED SERVICE means a service or supply for which We provide benefits. You incur a charge for a Covered Service on the date the service or supply is provided to You. Covered Service does not include any service or supply if the provision of that service or supply is not documented in provider records.

DEDUCTIBLE means a specified amount of Covered Services usually expressed in dollars. You must incur the Deductible before We assume any liability for all or part of the remaining Covered Services.

INDIVIDUAL DEDUCTIBLE means the amount each Member must pay per Calendar Year before We assume any liability for all or part of the Charges for Covered Services.

FAMILY DEDUCTIBLE means the maximum aggregate Deductible amount required under Employee plus one or Employee and two or more in a Calendar Year before We assume any liability for all or part of the Charges for Covered Services.

DENTIST means a licensed Doctor of Dental Surgery or equivalent, as recognized by the American Dental Association. Dentist includes any other professional practitioner authorized by law to practice dentistry at the time and place dental services are performed.

DEPENDENT means a Member other than You, the Subscriber. Please refer to Dependent Eligibility in the Eligibility section of this handbook.

EFFECTIVE DATE means the date on which a person's coverage under the Contract begins.

EXPEDITED GRIEVANCE means a grievance where the standard resolution process may include any of the following:

1. Serious jeopardy to the life or health of the Member or the ability of the Member to regain maximum function;
2. A situation where, in the opinion of a Dentist with knowledge of the Member's condition, the Member would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.

3. It is determined to be an expedited grievance by a Dentist with knowledge of the Member's dental condition.

EXPERIMENTAL/INVESTIGATIONAL means devices, drugs, biologic products, procedures, programs of diagnosis or treatment, or facilities for which there is a lack of scientific evidence permitting conclusions:

1. As to effect on health outcome;
2. That the net health outcome is beneficial;
3. That the beneficial outcome is better than that achieved under established alternatives; or
4. That the effect is attainable under the usual conditions of dental practice.

We determine whether a device, drug, biologic product, procedure, program of diagnosis or treatment, or facility is Experimental/ Investigational. The factors considered may include:

1. Current dental literature;
2. Recommendations of formal technology assessment programs;
3. Recommendations enclosed in policy statements developed by professional societies;
4. Expert opinions of clinicians in the dental community; or
5. Where applicable, final approval by the appropriate government regulatory body.

A request for an advance determination may be submitted in writing to the provider/customer service departments of the regional service center responsible for servicing the Group. If prior written approval for a treatment, service or supply is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment, service or supply is provided.

FAMILY COVERAGE means coverage for You, the Subscriber, and one or more of Your Dependents.

FEE SCHEDULE means that schedule of designated and specific fees for Covered Services as contained in the Preferred Provider Dental Agreement.

GRIEVANCE means a written complaint that You, or someone on Your behalf, files with Us. The complaint may involve Your dissatisfaction with Our administration or claims practices, the provision of services, denial of devices, or limitation for an Experimental / Investigational treatment.

GROUP means the employer or organization through which You have this coverage.

GROUP APPLICATION means the application for insurance completed and signed by the Group.

LIFETIME MAXIMUM BENEFIT means the total amount of benefits We will pay for any one Member while covered by the Contract.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY) means that the services or supplies provided by a Dentist are required to diagnose or treat Your Illness or Injury. We determine whether a service or supply is Medically Necessary based on the findings of a utilization review process and generally accepted dental practice. The service or supply must be:

1. Consistent with and appropriate for the treatment or diagnosis of Your symptoms, Illness or Injury;
2. Of proven value or usefulness, likely to yield additional information, and not redundant when performed with other procedures;
3. The most appropriate and cost effective level of service or supply which can safely be provided to You; and
4. Not primarily for the convenience of You, Your family or the Provider.

The fact that a Dentist has prescribed, ordered, recommended or approved a treatment, service or supply does not in itself make it eligible for payment.

MEDICARE means the hospital and medical insurance program established as Title I, Part I of Public Law 89-97 by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, and as later amended.

MEMBER means You, the Subscriber. If You have Family Coverage, Member includes Your Dependents.

NETWORK PROVIDER means a Provider that we have selected to participate in our Preferred Provider Program. The Provider has signed a written agreement with Us to provide Covered Services to Members.

OPEN ENROLLMENT PERIOD means an Enrollment Period when any eligible Employee of the Group may apply for this coverage.

ORTHODONTIST means a provider who performs orthodontic services within the scope of his or her license.

PARTICIPATING ORTHODONTIST means an Orthodontist who has entered into a written agreement with Us to provide orthodontic services to Our Members.

NON-PARTICIPATING ORTHODONTIST means an Orthodontist who does not have an agreement with Us.

ORTHOGNATHIC SURGERY means a Surgery designed to reposition the maxilla (upper jaw bone) and/or mandible (lower jaw bone). Its purpose is to achieve harmony in function and appearance between the jaws.

OSTEOTOMY means a type of Orthognathic Surgery which involves a surgical incision into the maxilla (upper jaw bone) and/or mandible (lower jaw bone). An Osteotomy may be classified as a Sagittal Split, a Segmental Osteotomy, a Subcondylar Osteotomy, and/or a Vertical Osteotomy.

PROBATIONARY PERIOD means the continuous length of time an employee must be employed with the Group before an employee and his or her eligible Dependents may apply and begin coverage under this Contract. The Probationary Period is shown in the Group application.

PROVIDER means a Dentist or Other Provider, licensed where required and performing within the scope of the license.

PREFERRED PROVIDER means a Provider that We have selected to participate in Our preferred provider program. The Provider has signed a Preferred Dental Agreement with Us.

NON-PREFERRED PROVIDER means a Provider that does not meet the definition of a Preferred Provider.

You will receive a list of Preferred Providers.

Our use of the terms "Preferred" and "Non-Preferred" is not a statement as to a Provider's ability.

SUBSCRIBER means a member of the Group who:

1. Meets the Group's eligibility requirements for fringe benefits;
2. Meets the Contract's eligibility requirements;
3. Has submitted a completed application to Us for coverage under the Contract; and
4. Has caused premium payment to be made on his or her behalf.

TREATMENT PLAN means a written report prepared by a Dentist, which shows the proposed treatment for a Member's dental disease, defect, or Injury. A Treatment Plan shows all necessary procedures, the series of visits, and the charges for the treatment.

USUAL FEE means the fee charged by the Provider for the service or item to the majority of his or her patients.

USUAL, CUSTOMARY, AND REASONABLE CHARGE means the amount We allow for a Service rendered by a Dentist. We determine the Usual, Customary, and Reasonable Charge for a given service or item. A Usual, Customary, and Reasonable Charge is not more than:

1. The Usual Amount, which is the fee charged by the Provider for the service or item to the majority of his or her patients; and
2. The Customary Amount, which is the fee that falls within a range of Usual Amounts of most Providers in the smallest geographic area that will generate a statistically credible claims distribution for the same or similar service; and
3. The Reasonable Amount, which is the Usual and Customary Amount taking into consideration the complexity of treatment required for the particular case.

If We receive too few claims for a service or item to enable Us to establish a UCR Rate, We will pay a fee for the service or item based on information from Providers of similar services or items, and any other information available.

WE, US, and **OUR** means BLUE CROSS BLUE SHIELD OF WISCONSIN.

YOU and **YOUR** means any Member, unless the booklet language refers specifically to the Subscriber or a Dependent.

SCHEDULE OF BENEFITS

INSURANCE PROVIDED

Dental benefits provided by DentalBlue are subject to the terms and conditions of this Contract. The Services must begin on or after Your Effective Date, be Medically Necessary, be furnished according to a Dentist's order, and not be performed for primarily cosmetic or aesthetic purposes.

DENTALBLUE SUPPLEMENTAL PLAN

What is Covered by the DentalBlue Supplemental Plan

The services listed in the following categories are covered under this plan:

- Basic Services
- Major Services

For a complete list of the DentalBlue Supplemental Plan Covered Services covered in each of the above categories, please refer to the Covered Services section.

Waiting Periods

A 0 month waiting period applies to Diagnostic and Preventive Services.

A 3 month waiting period applies to Basic Services, applies to new enrollees only.

A 3 month waiting period applies to Major Services, applies to new enrollees only.

During a waiting period you will not be eligible for benefits.

While insured under this Contract you will be responsible for a share of the cost for DentalBlue Supplemental Plan Covered Services. Your share is as follows:

DentalBlue Supplemental Plan Deductible

- \$50 per Member per Calendar Year
- \$100 per Employee and one Dependent per Calendar Year
- \$150 per Family (Employee plus two or more dependents) per Calendar Year

The Deductible applies to Basic, Major, and Complex Specialty Services only.

DentalBlue Supplemental Plan Coinsurance

You will be responsible for a portion of Your Dentist's Usual, Customary, and Reasonable Fee. Your portion is as follows:

Basic Services

- You pay 25% of the Dentist's Usual, Customary, and Reasonable Fee, after the Deductible.

Major Services

- Complex Endodontic Services

You pay 50% of the Dentist's Usual, Customary, and Reasonable Fee, after the Deductible.

- Complex Periodontic Services

You pay 50% of the Dentist's Usual, Customary, and Reasonable Fee, after the Deductible.

- All Other Major Services

You pay 50% of the Dentist's Usual, Customary, and Reasonable Fee, after the Deductible.

The Coinsurance applies to all Covered Services, except Orthodontic Services.

MAXIMUM BENEFITS

Aggregate Maximum - \$1,000 per Member per Calendar Year.

Applies to all Covered Services except Orthodontic Services.

Any charges beyond the above-listed maximums will be the Member's responsibility to pay.

THE BASIC ORTHODONTIC PLAN

What is Covered by the Basic Orthodontic Plan

The services listed in the following categories are Covered Orthodontic Services:

- Orthodontic Diagnostic Services
- Orthodontic Treatment Services

For a complete list of services covered in these categories, please refer to the Covered Services section.

Basic Orthodontic Plan Benefit

We have contracted with certain Orthodontists to provide our Members with a discount on Orthodontic Services. You will be responsible for a portion of Your Participating Orthodontist's Usual Fee for Basic Orthodontic Plan Covered Services, as defined below:

- Orthodontic Diagnostic Services - You pay 80% of Your Participating Orthodontist's Usual Fee. The Participating Orthodontist agrees to waive the remaining 20%, up to the Maximum Benefit.
- Orthodontic Treatment Services - You pay 80% of Your Participating Orthodontist's Usual Fee. The Participating Orthodontist agrees to waive the remaining 20%, up to the Maximum Benefit.

This benefit only applies to Basic Orthodontic Plan Covered Services received at Participating Orthodontists. You will make payment directly to Your Orthodontist according to the terms and methods defined by Your Orthodontist.

Basic Orthodontic Plan Maximum Benefits

The maximum discount available for Basic Orthodontic Services received from a Participating Orthodontist is \$1000 per Member per lifetime.

Any charges beyond the above-listed maximum discount will be the Member's responsibility to pay.

COVERED SERVICES

DENTALBLUE SUPPLEMENTAL PLAN COVERED SERVICES

Basic Services

Benefits are limited to the procedures that are Medically Necessary to achieve restoration. This means that if an amalgam restoration would give a satisfactory result, but You and Your Dentist choose a resin restoration, the balance of the cost for the resin restoration is Your responsibility.

- A. Amalgam (Silver) Fillings**
- B. Resin (Tooth-Colored) Fillings** - Permanent Anterior (front teeth)
- C. Simple Endodontics** - Pulpotomy, Pulpal therapy
 - Limited to 1 treatment per tooth.
- D. Simple Oral Surgery** - Simple extractions, removal of exposed roots
- E. Simple Periodontics**
 - 1. Periodontal scaling and root planing, per quadrant
 - Limit of 4 quadrants scaling and root planing per Member, per 36 consecutive months.
 - 2. Full mouth debridement to enable periodontal evaluation
 - Limit of 1 debridement per Member, every 36 months.
 - Not covered when performed on the same visit as Prophylaxis adult or child Prophylaxis, with or without fluoride.

Major Services

A. Single Unit Prosthodontic Restorations (Crowns)

We will cover the initial insertion of single prosthodontic restorations. Replacement of initial restorations will only be covered if 5 years have elapsed since the initial insertion of the appliance.

We will cover up to a maximum of 4 single and/or multiple unit fixed restorations in any Calendar Year.

The single unit fixed prosthodontic restorations are covered only when the tooth, as a result of extensive caries or fracture, cannot be restored by a direct filling procedure. If a tooth can be restored with a direct filling procedure, but the Member and Dentist select another type of restoration, We pay the benefits that We would otherwise pay for the direct filling procedures. The balance of the treatment charge is the Member's responsibility.

1. Crowns - Resin, Porcelain, Full Cast, Prefabricated stainless steel, Recementation
 - If the Member and Dentist select a metal other than base metal for a crown, We will only pay benefits based of the base metal crown. The balance of the treatment charge would be the Member's responsibility.
 - We will not cover crowns when used as a treatment for bruxism.
2. Sedative filling
3. Other crown services - core buildup including pins, pin retention per tooth in addition to restoration, prefabricated post and core in addition to crown, post removal

B. Removable Prosthodontic Restorations (Dentures)

We will cover the initial insertion of prosthodontic restorations. Replacement of initial restorations will only be covered if 5 years have elapsed since the initial insertion of the appliance.

For partial dentures, if a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, but the Member and Dentist select a more elaborate or precision appliance, We pay the benefits that We would otherwise pay for the cast chrome or acrylic partial denture. The balance of the cost is the Member's responsibility.

For full dentures, if the Member and Dentist decide on personalized restorations or specialized techniques instead of standard procedures, We pay the benefits that We would otherwise pay for standard denture services. The balance of the cost is the Member's responsibility.

1. Dentures - complete dentures, immediate dentures, upper & lower
2. Partial Dentures - resin base including any conventional clasps, rests and teeth

3. Partial Dentures - resin base, cast metal framework including any conventional clasps, rests and teeth

C. Multiple Unit Fixed Prosthodontic Restorations (Bridges)

If a removable partial denture can provide professionally acceptable treatment and is less costly, We will only pay benefits based upon the cost of a removable partial denture.

We will cover the initial insertion of prosthodontic restorations.

Replacement of initial restorations will only be covered if 5 years have elapsed since the initial insertion of the appliance.

If a Member and Dentist select a metal other than base metal, We only pay benefits based on the cost of the base metal restoration.

We will cover up to a maximum of 4 single and/or multiple unit fixed restorations in any Calendar Year.

1. Pontics - resin, porcelain, cast metal
2. Retainer - cast metal for resin bonded fixed prosthesis
3. Crowns - resin, porcelain, 3/4 cast metallic, full cast

D. Other Prosthetic Services

For replacement of an existing removable partial or full denture, or a fixed bridge, or the addition of teeth to an existing removable partial denture or bridge, the Member or Dentist must provide satisfactory evidence that:

- a. The replacement of teeth or addition of teeth is required to replace one or more teeth extracted after the existing removable partial or bridge was inserted; or,
- b. The existing denture or bridge was inserted at least 5 years before its replacement and the existing denture or bridge cannot be made serviceable; or,
- c. The existing denture is an immediate temporary full denture which cannot be made permanent. Replacement by a permanent denture must take place within 12 months from the date of the initial insertion of the immediate temporary full denture.

Double abutments are covered only when Medically Necessary

Treatment partials are covered only when used as a space maintainer for Members under 19 years of age.

Any relines or rebases, adjustments or repairs during the first 6 months after the insertion of the appliance are covered as part of the initial fee for that appliance. After 6 months, a reline or a rebase is covered once every 36 months.

Costs for repairs and adjustments are covered after 6 months from the date of insertion of said appliance.

The following procedures must be accompanied by a written dentist report:

1. Repair broken complete denture base, resin denture base, cast framework, broken clasp
2. Replace missing or broken teeth - complete denture (each tooth)
3. Recement bridge
4. Adjustment of complete or partial denture
5. Addition of teeth, clasps to existing complete or partial denture
6. Rebase complete or partial denture
7. Reline complete or partial denture, chairside or laboratory
8. Cast post as part of bridge retainer, must be accompanied by written dentist report
9. Prefabricated post and core in addition to bridge retainer, must be accompanied by written dentist report
10. Core build up for retainer, including any pins, must be accompanied by written dentist report

E. Complex Endodontics

- Limited to 1 treatment per tooth.

1. Root canal therapy - Anterior, Bicuspid, Molar
2. Retreatment of previous root canal therapy - Anterior, Bicuspid, Molar
3. Apexification / recalcification - Initial, Interim, and Final Visit
4. Apicoectomy / Periradicular surgery - Anterior, Bicuspid, Molar
5. Root Amputation and Hemisection
6. Canal Preparation and Fitting of Preformed Dowel or Post

F. Complex Periodontics

Periodontal surgeries are limited to a total of 4 quadrants in a 36 month period.

1. Gingivectomy or Gingivoplasty
2. Gingival flap procedure
3. Osseous Surgery
4. Pedicle and free soft tissue graft procedure, bone replacement grafts
 - Limit of 4 grafts per Calendar Year.
5. Periodontal maintenance procedures
 - Limited to 2 periodontal maintenance procedures in 12 consecutive months following periodontal surgery.

ORTHODONTIC CARE PLAN COVERED SERVICES

Replacement or repair cost of an orthodontic appliance is the Member's liability. If a Member chooses personalized or more elaborated braces other than the standard metal braces, payment shall be limited to the applicable percentage of the cost of the standard braces and the balance of the cost shall be the responsibility of the Member.

If such orthodontic treatment is terminated for any reason before completion, the obligation of the plan to provide benefits thereafter shall cease as of such date of termination. If such services are resumed, benefits shall resume, to the extent of remaining coverage.

Diagnostic Orthodontic Services

The services below are subject to the levels identified in the Schedule of Benefits, and will only be covered when performed by an orthodontic services provider in conjunction with orthodontic treatment.

A. Exams

1. Comprehensive oral evaluation
2. Detailed and extensive oral evaluation

B. X-rays

1. Panoramic film
2. Cephalometric film

C. Other Diagnostic Services - Diagnostic photographs and casts

Orthodontic Treatment Services

D. Limited Orthodontic Treatment - of the Primary, Transitional, Adolescent, and Adult Dentition

E. Interceptive Orthodontic Treatment - of the Primary and Transitional Dentition

F. Comprehensive Orthodontic Treatment - of the Transitional, Adolescent, and Adult Dentition

G. Other Orthodontic Treatment

1. Pre-orthodontic treatment visit
2. Orthodontic retention - removal of appliances, construction, and placement of retainer(s).

Treatment Transfers

A change of orthodontists while in active orthodontic treatment may be undesirable due to the ongoing nature of orthodontics and varying accepted treatment methods and principles. In the event that the orthodontic records from the previous orthodontist are necessary, the Member is responsible for obtaining these records and any applicable duplicating costs for the records.

GENERAL EXCLUSIONS

No benefits are available for:

1. Services, supplies, or equipment which:
 - a. Are not specifically described in this Contract; or
 - b. Are furnished in connection with or as a result of a non-covered service, even though the services, supplies, or equipment would otherwise be Covered Services.
2. Services, supplies, or equipment furnished:
 - a. Before the Member's Effective Date; or
 - b. After the date the Member's coverage ends, except for:
 - 1) Prosthetic devices which were ordered and fitted before, and completed within 60 days after, the date the Member's coverage ends; and
 - 2) Procedures, other than prosthetics, which were begun before, and completed in one visit within 30 days after, the date the Member's coverage ends.
3. Any portion of a charge which is more than the Charge as defined in this Contract.
4. Services, supplies, or equipment that are not Medically Necessary.
5. Services, supplies or equipment that are Experimental / Investigational.
6. Covered Services provided by a Dentist who is a member of the Member's immediate family. Immediate family means the Subscriber's or Member's spouse, children, parents, grandparents, brother and sisters and their spouses.
7. Covered Services rendered or furnished in connection with elective plans of treatment. To the extent that they are available, We provide benefits for the suitable plan carrying the lesser fee.
8. Covered Services for congenital malformations, or primarily for cosmetic or esthetic purposes. This exclusions applies to existing teeth, not to congenitally missing teeth. This exclusion does not apply to Covered Services necessary to achieve normal body functioning.

9. Charges for:
 - a. Any duplicate appliance or device;
 - b. The Replacement of a lost, stolen, or missing crown or prosthetic device;
 - c. The replacement or repair of an orthodontic appliance.
10. Charges for:
 - a. Oral hygiene counseling and dietary instruction;
 - b. Plaque control programs;
 - c. Implantology;
 - d. Splinting procedures;
 - e. Study models / diagnostic casts, unless done as part of orthodontic services which are eligible for Contract benefits;
 - f. Temporary crowns;
 - g. Nitrous oxide analgesia;
 - h. Occlusal adjustments;
 - i. Fees for prescription drugs;
 - j. Injections of antibiotic drugs;
 - k. The cost of high noble metals; unless Medically Necessary to restore the tooth;
 - l. Gold foil restorations or implants;
 - m. Bacteriologic studies, caries susceptibility tests, histopathology examinations, and other oral pathologic procedures.
11. Charges for Covered Services for which benefits are otherwise provided or available to a Member under a hospital and/or surgical/medical or prescription drug benefit program.
12. Precision attachments, precision partials, or treatment partials except as specified in the Covered Services section.
13. Prosthodontics to replace those teeth lost or missing before the Member's Effective Date, if the Member did not enroll during his or she first available enrollment period.
14. Charges for porcelain, veneers or similar properties of crowns and pontics placed on or replacing teeth numbers 1,2,3,14,15,16, 17,18,19,30,31, and/or 32 or their deciduous equivalents.

15. Appliances, restorations, or procedures needed to adjust vertical dimension or to restore occlusions, except as an integral part of comprehensive orthodontic treatment.
16. Orthognathic Surgery or Osteotomies.
17. Treatment of Temporomandibular Joint Disease.
18. Covered Services for any illness or injury:
 - a. Which occurs in the course of employment; and
 - b. For which the Member is eligible for compensation, in whole or in part, under any Worker's Compensation Act or Employer Liability Law.

This exclusion applies whether or not the Member:

- a. Claims the benefits or compensation; or
 - b. Recovers losses from a third party; or
 - c. Has Worker's Compensation coverage.
19. Covered Services resulting from an illness contracted or injury sustained as a result of:
 - a. War, whether declared or undeclared; or
 - b. Service in the armed forces of any country or state.
 20. Services, supplies, or equipment to the extent benefits are provided or could have been obtained by any governmental unit.
 21. Services, supplies or equipment to the extent the Member is eligible for Medicare benefits by reason of age, disability, or special programs. In such cases, Medicare is the Member's primary payor, except where Medicare is secondary by law. Where Medicare is primary payor, no benefits are available for services, supplies, or equipment for which the Member would have been entitled to Medicare benefits had he or she enrolled in Medicare, complied with Medicare requirements, or not declined or discontinued Medicare coverage.
 22. Any services, supplies or equipment which are required to be provided by a public school district or state or local educational agency pursuant to the requirements of the federal Individuals with Disabilities Education Act, 20 U.S.C. § 1401 et. seq., as amended, or any state or local law(s) and regulation(s) which implement such act. This exclusion applies whether or not the

service is actually provided by the public school district or educational agency.

24. Free care - care which was, or could have been, obtained free of charge from any source, or care for which You would have no legal obligation to pay if You did not have this or any similar coverage.
25. Services, supplies, or equipment received from a dental or medical department maintained by or on behalf of a/an:
 - a. Employer;
 - b. Mutual benefit association;
 - c. Labor union;
 - d. Trust;
 - e. Academic institution;
 - f. Similar person or group.
26. The following charges:
 - a. Charges for failure to keep a scheduled visit;
 - b. Charges for completion of a claim form;
 - c. Charges which are not documented in provider records;
 - d. Federal, state or local tax on goods or services; or
 - e. Charges for services not requested by a Dentist's order, or documented in provider records;
 - f. Charges for telephone consultation;
 - g. Charges for return to work / school form;
 - h. Additional charges beyond the charges for basic and primary services for services requested after normal provider service hours or on holidays;
 - i. Hospital or physician services of any kind.
27. Additional orthodontic fees that are a direct result of lack of patient cooperation, including without limitation, missed appointments and failure to wear appliances.
28. Any laboratory charges, except when specifically provided in the Contract.
29. Placement of bone grafts, or extra-oral substances; treatment of cleft palate and LeForte I, II, and III procedures

30. Charges for any form of anesthesia, including General Anesthesia, Local Anesthesia, and Nitrous Oxide.
31. Additional dental fees that are a direct result of lack of patient cooperation, including without limitation, missed appointments and failure to follow the Dentist's recommendations in order maintain the effectiveness of treatments and good oral health.
32. Treatment for bottle caries.
33. Treatment for bruxism.
34. Full mouth reconstruction.
35. Charges for treatment required as a result of an accidental injury.

COORDINATION OF THE CONTRACT'S BENEFITS WITH OTHER BENEFITS

APPLICABILITY

This Coordination of Benefits ("COB") provision applies to This Plan when a Member has dental care coverage under more than one Plan, except to the extent this provision is superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

If this COB provision applies, the order of benefit determination rules are looked at 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. Are not 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 Effect On The Benefits Of This Plan section below.

DEFINITIONS

When used in this Section only, these terms have the following meanings.

ALLOWABLE EXPENSE means a necessary, reasonable, and customary item of expense for dental care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an Allowable Expense and a benefit paid.

CLAIM DETERMINATION PERIOD means a calendar year. However, 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 which provides benefits or services for, or because of, dental care or treatment:

1. Group dental insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice dental coverage. It also includes dental 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, of the United States Social Security Act as amended from time to time). It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1. or 2. is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

PRIMARY PLAN/SECONDARY PLAN. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

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 the part of the Contract that provides benefits for dental care expenses.

ORDER OF BENEFIT DETERMINATION RULES

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 require that This Plan's benefits be determined before those of the other Plan.

This plan determines its order of benefits using the first of the following rules which applies:

1. **NON-DEPENDENT/DEPENDENT.** The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the person as a dependent.
2. **DEPENDENT CHILD/PARENTS NOT SEPARATED OR DIVORCED.** Except as stated in rule 3, 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 that calendar year; but
 - b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

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 health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to rule 2.

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

- 4. **ACTIVE/INACTIVE EMPLOYEE.** The benefits of a Plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan which covers that person as a former 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 is ignored.
- 5. **CONTINUATION COVERAGE.** The benefits of a Plan which covers a person as an employee, member, or subscriber, or as a dependent of such a person, are determined before those of a Plan which covers that person as a person on state or federal continuation. 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 is ignored.
- 6. **LONGER/SHORTER LENGTH OF COVERAGE.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

EFFECT ON THE BENEFITS OF THIS PLAN

This Section applies when, in accordance with the Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans".

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

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.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need. We may get needed facts from, or give them to, any necessary organization or person. We need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

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

DISENROLLMENT

We will cover You as long as You pay Your premium. But We can disenroll You and/or all other members of Your family in the following circumstances:

1. You and/or Your employer fail to pay Your premium due on a timely basis.
2. We discover that You or a dependent have furnished fraudulent information.
3. You or a dependent misuse Your DentalBlue identification card.
4. You or a dependent commit acts of physical or verbal abuse which pose a threat to Providers and to DentalBlue.

We will give You at least 10 days written notice before disenrollment. If We disenroll You and/or Your dependents for any reason other than for nonpayment of the premium, We will make arrangements to provide alternate coverage. This alternate coverage continues until You find Your own coverage or until You have a chance to change insurers, whichever comes first.

TERMINATION OF COVERAGE

TERMINATION OF GROUP COVERAGE

The Group's coverage under this Contract ends on the earliest of:

1. Failure to pay premium when due.
2. Fraud or intentional misrepresentation of a fact material to coverage under this Contract by the Group.
3. Failure to meet the minimum contribution or participation requirements.
4. The date the Group ceases active business operations or is placed in bankruptcy or receivership.
5. The date the Group loses its identity by means of a dissolution, merger, or otherwise.
6. The last day of the calendar month for which premium payment is made provided the Group gives Us 30 days advance notice of the termination date.
7. The date we decline to renew the Contract.

TERMINATION OF INDIVIDUAL COVERAGE

Except as specified in the Contract, a Member's coverage ends on the earliest of the following dates:

1. The date the Contract between the Group and Us terminates. It is the Group's responsibility to notify all Subscribers of the termination of coverage.
2. The last day of the month in which the Member no longer meets the eligibility requirements.
3. The last day of the month in which the last premium contribution is made by or on behalf of the Subscriber.
4. The last day of the month in which You, the Subscriber, or any of Your Dependents are disenrolled.

The Group must notify Us of the termination of a Member's coverage on or before the termination date. Except as stated below, no benefits are available to a Member for Covered Services rendered after the date coverage ends.

CONTINUATION PRIVILEGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 allows You to continue Your coverage beyond the date it would normally end. Check with Your Group to find out how the law applies to You.

The section below, entitled Continuation Of Coverage under COBRA contains the continuation requirements of this Act. Groups may be subject to this Act. If so, they must comply with the minimum requirements of the Act. The intent of this Contract is to comply with the minimal legislative requirements of COBRA. If the law is amended, thus affecting a provision of this Contract, We deem that provision amended and will administer the Contract accordingly. It is the Group's responsibility to determine which provisions apply to the Group.

CONTINUATION OF COVERAGE UNDER COBRA

1. Upon the occurrence of an event set forth in paragraph 2 below, the following persons who have been covered under this Contract may elect to continue coverage under this Contract.
 - a. The spouse of a Subscriber, upon the occurrence of event 2-a, 2-b, 2-c, or 2-d;
 - b. The Dependent child of a Subscriber, upon the occurrence of event 2-a, 2-b, 2-c, or 2-d;
 - c. The Subscriber, upon the occurrence of event 2-b;
 - d. The retired Subscriber and any of his Dependents who are Members, upon the occurrence of event 2-f;
 - e. Widows or widowers of retired Subscribers who died before the occurrence of event 2-f, upon the occurrence of that event.
2. If one of the following events occurs and results in the loss of coverage under this Contract for a person described in paragraph 1, he or she may continue coverage.
 - a. Death of the Subscriber;
 - b. Termination of the Subscriber's employment or reduction in hours under this Contract. This does not include a Subscriber who terminates eligibility for coverage due to discharge for gross misconduct shown in connection with his or her employment;

- c. Eligibility of the Subscriber for Medicare;
- d. Divorce or legal separation of the Subscriber;
- e. End of the eligibility of a child of the Subscriber as a Dependent under this Contract; or
- f. The Group's filing of a Chapter 11 bankruptcy petition.

The Subscriber or the Member whose coverage is terminated due to the occurrence of an event listed in d or e above must provide the Group notice of that event within 60 days of its occurrence.

- 3. If the Group is notified to terminate a Member's coverage for any of the reasons set forth in paragraph 2 above, the Group will send to the Member's home address, as shown on the Group's records, or deliver personally written notification of:
 - a. The right to continue coverage under this Contract; and
 - b. The payment amounts needed to continue coverage. This includes the manner, place and time in which payment must be made.

The Group will give notice not more than 14 days after receiving notice to terminate coverage. Except as provided for in paragraph 6-f, the premium for continued coverage under this Contract will not be more than 100% of the rate in effect for a Group member, including the Group's contribution.

- 4. The terminated Member must elect continued coverage and pay the premium within the election period. This is a period of 60 days from the later of:
 - a. The date of the event set forth in paragraph 2 that led to termination; or
 - b. The date the terminated Member receives notice under paragraph 3 above.

He or she also has 45 days from the date he or she elects continued coverage in which to pay to the Group the premium required for the continued coverage provided during the period immediately preceding the election date.

If the terminated Member is a minor, his or her parent or guardian may act on his or her behalf. A terminated Subscriber may continue coverage for his or her spouse or dependents who were also covered by this Contract. A terminated Subscriber may change coverage status from single to Family Coverage upon birth or adoption of a new child during the period of continued coverage. He or she must pay any additional premium.

5. We treat a terminated Member who continues coverage under this Contract in the same manner as a similarly situated Member whose Contract coverage has not terminated.
6. Coverage of the terminated Member continues until the earliest of the following occurs:
 - a. The Group ceases to provide this Contract to any employees.
 - b. The terminated Member fails to pay a required premium amount by the end of the grace period.
 - c. The terminated Member becomes covered as an employee or otherwise under any other group benefit plan which contains no pre-existing condition limitations or exclusions.
 - d. The terminated Member becomes covered as an employee or otherwise under any other group benefit plan which contains a pre-existing condition limitation or exclusion which the Member has satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended.
 - e. The end of a period of 18 months after the occurrence of event 2-b, or 36 months after the occurrence of event 2-a, 2-c, 2-d, or 2-e. However:
 - 1) If the Social Security Administration determines that a Subscriber or Dependent who is eligible for continued coverage because of event 2-b is disabled within 60 days of the event, then the Subscriber's coverage, and that of his/her covered Dependents, continues until the earlier of the end of the disability or the end of a period of 29 months after the occurrence of event 2-b. The Subscriber or Dependent must notify the Group of the Social

Security Administration's determination within 60 days of the determination, and before the end of the eighteenth month of continuation. The premium for the nineteenth through twenty-ninth month of continued coverage will not be more than 150% of the rate in effect for a Group member, including the Group's contribution.

- 2) If a retired Subscriber dies after the Group files a Chapter 11 bankruptcy petition, continued coverage for his or her surviving spouse and children who are Members expires at the end of a period of 36 months after the Subscriber's death.
 - 3) In all other cases, if a terminated Member, other than a Member described in paragraph 1-e, experiences more than one of the events set forth in paragraph 2, the maximum period of continuation is 36 months from the date of the first event.
7. The terminated Member pays premium for continued coverage to the Group. The Group collects the premium, and We bill the Group for the premium. We charge to the Group the claims experience of individuals whose coverage is continued.

GENERAL PROVISIONS

MEMBER/PROVIDER RELATIONSHIP

Nothing herein contained shall interfere with the professional relationship between You and Your Dentist.

The Plan shall in no way be responsible for any act or omission of any Dentist or other professional practitioner or their agents, to provide Covered Service. The obligation of the Plan shall be limited solely to provide Benefits according to the provisions in the Contract.

REIMBURSEMENT

If We pay benefits on behalf of You or Your Dependents in excess of the benefits required by this Contract, You must reimburse Us the excess benefits. The reimbursement is due and payable as soon as We notify You and demand reimbursement. We may also recover benefits paid from any person or provider to whom the payments were made. We may reduce benefits or an allowance for benefits as a set-off toward reimbursement. Even though We continue to provide or pay benefits, We may still enforce this provision. This provision is in addition to, not instead of, any other remedy We have at law or in equity.

NOTICE OF CLAIM

The Member must present his or her identification card to the Dentist when he or she applies for benefits.

PROOF OF LOSS

Either You or Your Provider of service may submit Your claim. In either case, We must receive proof of loss within 90 days after You receive medical services or supplies.

We will still process the claim if:

1. It was not reasonably possible for You to give Us proof of loss within 90 days; and

2. You give Us proof as soon as You are reasonably able, but not more than 15 months after You receive care.

Claims which We receive more than 15 months after You receive care will not be processed or paid.

PAYMENT OF CLAIMS AND GRIEVANCE PROCESS

Your benefits may not be assigned. They are payable directly to You, the Subscriber. However, at Our option, We may choose to make payment directly to the Provider of services. If You or Your Dependent sign a claim form indicating that the Provider is to be paid directly, We accept that signature as authorization to exercise Our option. We may also pay the Provider directly if the Provider has a written agreement with Us.

We will send You written notice regarding the claim within 30 days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or nonpayment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. You may contact Our Customer Service department for more details of Our decision.

If You still disagree with Our claim payment or denial, You may file a Grievance. The Grievance must:

1. Be in writing;
2. Provide pertinent information such as identification number, patient's name, date and place of service, and reason for requesting the review.

It will be helpful if You identify the Grievance as a Grievance appeal. We will acknowledge the Grievance within 5 business days of receiving it.

You may appear in person before the Grievance committee to:

1. Present written or oral information; and
2. Question the persons responsible for making the decision that resulted in the Grievance.

We will notify You of the time and place of the Committee meeting at least 7 days before the meeting.

After review, We will provide a written decision, including reasons, within 30 days of receiving the Grievance. If special circumstances require a longer review period, We will provide Our written decision within 60 days of receiving the Grievance. If We need the extra days, We will notify You of the reason why, and when a decision may be expected.

If the Grievance involves a situation that qualifies as an Expedited Grievance, as defined in the Definitions section, You may file the Expedited Grievance via a telephone call to Us. You must provide the pertinent information listed above. We will resolve the Expedited Grievance within 72 hours of receiving it.

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to:

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

or You can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

ALLOWABLE CHARGES VERIFICATION

You may contact Our Customer Service area prior to having a procedure performed to determine if the provider's estimated charge is within our allowable Charge. You must provide Us with the following information:

1. Date of service;
2. Place of service;
3. Valid 5 digit C.P.T. or A.D.A. code; and
4. Provider's estimated charge.

DENTIST PAYMENT DISAGREEMENTS

When a Dentist's bill for Covered Services is more than what We paid as the Charge, You should not be billed the difference. When Covered Services are obtained from a Preferred Provider or a Participating Orthodontist, You are only responsible for any Copayments, Coinsurance, or expenses applied toward a Deductible. If a dispute arises between You and a Preferred Provider or Participating Orthodontist because the bill for a covered Service is more than what We paid as the Charge, You may refer the dispute to Us. We will:

1. Provide a defense to legal action brought against You;
2. Pay the cost of the defense and taxable court costs; and
3. Satisfy any judgment or settlement reached.

You, or a responsible party on Your behalf, must actively cooperate and participate with Us in defense of the suit. This includes:

1. Immediately furnishing Us with copies of all legal process;
2. Providing requested information; and
3. Assisting in securing and giving evidence. This means attending conferences, hearings and trials. It also means helping obtain the attendance of other witnesses at legal proceedings related to the suit.

We have the right to settle a disagreement or suit at any stage of proceedings. We may continue a suit through ultimate appeal.

This provision only applies to a Dentist who has a contract with Us to render or provide services or supplies covered under this Contract.

RELEASE OF INFORMATION

You must do all things reasonably necessary to help Us determine benefits payable. This includes authorizing the release of medical or dental information, including names of all Dentists from whom You received treatment. We have no liability for any charge made by a Provider for the copying or furnishing of the information.

VERIFICATION OF BENEFIT CLAIM

We have the right to accept or to require verification of any alleged fact or assertion relating to a claim for benefits. In order to determine benefits payable, We may require the Member or Dentist to submit radiographs or other appropriate diagnostic and evaluative material.

TRANSFER OF BENEFITS

Only You, the Subscriber, and Your Dependents, as shown on Our records, are entitled to Contract benefits. These rights are forfeited if You or any Dependent:

1. Transfer those rights; or
2. Aid any person in fraudulently obtaining Contract benefits.

You and Your Dependents must reimburse Us for any benefits We have paid in this context.

DETERMINATION OF BENEFITS

1. If benefit levels change under this Contract, You are entitled to the level of benefits in effect on the date services or supplies were rendered.
2. You may request an advance determination as to whether a treatment, service, or supply is a Covered Service. Submit the request in writing to the Customer Service department of the regional service center responsible for servicing the Group. Where We give prior written approval, We pay benefits if, at the time the treatment, service, or supply is provided:
 - a. The Member's coverage is in force; and
 - b. Our approval has not expired.
3. Benefits under this plan will be paid only if the We decide in Our discretion that the applicant is entitled to them. The Group gives Us the discretionary authority to determine eligibility for coverage and benefits, and to construe the terms of the Contract. Furthermore, We have the right to determine the parameters used to identify claims that will be investigated. Our decisions shall not be overturned unless determined to be arbitrary and capricious.

4. We will consider alternative treatment plans proposed by You or on Your behalf. As part of this, We may extend benefits for services which are not Covered Services. The services must be Medically Necessary, cost-effective for Us, and feasible. We do this on a case-by-case basis. We may stop the extra benefits at any time.

We will not provide more benefits than the lifetime maximum specified. Under no circumstances does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. Offer or confirmation of alternative benefits in one instance does not obligate Us to provide to that or any other Member the same or similar benefits in another instance where the alternative treatment is not Medically Necessary, cost-effective for Us, and feasible. In addition, We do not waive Our right to enforce this Contract in strict accordance with its express terms and conditions.

SUBROGATION

Members who receive Covered Services according to the terms of this Contract, on behalf of themselves and anyone to whom their rights may pass, agree that in return for those services:

1. they hereby transfer and assign to Us, concurrent with, and to the extent of the value of Covered Services received or to be received, all rights to damages, reimbursement, or payment from any person, organization or insurer. Those assigned rights include, but are not limited to, rights against:
 - a. any automobile liability insurance;
 - b. any underinsured or uninsured motorist insurance;
 - c. where permitted by state law, any automobile medical payments or no-fault/personal injury protection insurance;
 - d. any homeowner liability insurance;
 - e. any applicable umbrella insurance;
 - f. medical malpractice insurance or patient compensation fund insurance; and
 - g. anyone liable for paying losses or damages.

2. they will not include in their claim for damages, reimbursement, or payment from any person, organization or insurer, that portion of the claim which has been transferred and assigned to Us; and
3. they will cooperate with Us in Our effort to recover from any person, organization or insurer the value of the Covered Services received by the Member, such cooperation to include, but not be limited to, providing Us with reasonable prior notice of and opportunity to participate in any such claim or settlement of such claim. They also agree to do nothing at any time to compromise Our claim or at any time, to hinder or otherwise prejudice Our right of recovery against any person, organization or insurer. If the Member does anything to prejudice our right of recovery, such act shall constitute a breach of this Contract. Our right of recovery is not prejudiced if our cause of action is not extinguished. The Member further agrees to not enter into any settlement arrangement with any person, organization or insurer without Our prior written consent. In the event a Member enters into such a settlement arrangement, such act shall be deemed to have prejudiced Our rights and shall be a breach of this Contract.

We shall have no right to recover from the Member if the Member has not been made whole in the complete and final resolution of a claim. The complete and final resolution of a claim includes the total of any and all sums received or to be received, regardless of the source. It is understood and agreed that whether one has been made whole is a determination which takes into consideration the comparative negligence, if any, of the Member. Should a dispute exist as to whether the Member has been made whole, such dispute shall be resolved by a judicial and jury determination. Said determination shall be conducted as any other civil jury trial. The rules of evidence shall govern the determination and the finder of fact shall determine the dollar amount which makes the Member whole.

WORKER'S COMPENSATION

This policy is separate from Worker's Compensation insurance. It does not satisfy any legal requirement for that insurance. If You receive Covered Services for any Illness or Injury for which You are or would have been eligible for an award, settlement or compromise, in whole or in part, under any Worker's Compensation or Employer Liability Law, You consent to direct reimbursement to Us out of the proceeds available or which would have been available under such law to the extent of the value of the Covered Services You receive.

VALUE OF COVERED SERVICES

For purposes of subrogation, reimbursement or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount We paid for the Covered Service. Where a Provider is paid on a capitated basis, the value shall be based upon the UCR Rate which would have otherwise applied to that Covered Service at the time the claim was adjudicated.

LEGAL ACTION

You may not start legal action against Us until the earlier of:

1. Sixty (60) days after You file notice of claim and complete the claim appeal / grievance process; or
2. The date We deny the claim and You complete the claim appeal / grievance process.

You may not start legal action against Us later than three (3) years from the time written proof of loss was required to be filed. You must file written proof of loss within twelve (12) months of the date of service. This means any legal action must be started within forty-eight (48) months of the first date of services on which the action is based.

Despite the above provisions, You may opt to commence legal action before completing the claim appeal / grievance process. If You do so, We may argue that Your lawsuit is premature and that the court should require you to first complete the claim appeal / grievance process.

INCONTESTABILITY

1. After coverage has been in effect for 2 years, We will not use a statement made by a Subscriber with respect to the Subscriber's or a Dependent's insurability to:
 - a. Void the Subscriber's contract
 - b. Deny a claim for benefits for services rendered or a disability commencing after the 2 years.This provisions does not apply to fraudulent misstatements.
2. We cannot reduce or deny a claim for benefits for services rendered or a disability commencing after 2 years from the Effective Date on the grounds that a condition existed before the Effective Date unless, at the time of claim, a provision excluding the condition by name or specific description was in effect.

REPRESENTATIONS

We deem any statement made by You, the Subscriber to be a representation, not a warranty. We will not use Your statement against You unless the statement is in a written application signed by You. We will give You or Your beneficiary a copy of the application.

ENTIRE CONTRACT

The Contract, its amendments, and the Group Application make up the entire contract of insurance between the Group and Us. No change to this Contract is effective unless it is:

1. Signed by one of Our executive officers; and
2. Made a formal amendment to the Contract. No agent has the authority to change this Contract or waive its provisions.

APPLICABLE LAW

To the extent this Contract is subject to state law, it is construed under, enforced according to, and governed by the laws of the state in which it is delivered. If any Contract provision conflicts with that state's statutes, We deem that provision changed to comply with the statutes. The rest of the Contract remains in full force and effect.

NOTICE

Any notice required by this Contract must be in writing. Notice to the Group or Us will be sent to the addresses shown in the Group Application. Notice to a Member will be sent in care of the Group, or to the address appearing in Our records. The Group, the Member, or We, may, by written notice, give a new address for giving notice.

DOMESTIC PARTNER BENEFITS RIDER

Notice: The information in this Rider was supplied by your Employer. Any questions regarding Domestic Partner coverage should be submitted to your Employer.

This Domestic Partner Benefits Rider amends the Definitions, Eligibility, Termination, and General Provisions sections of the above-referenced plan, as issued by CompCare Health Services Insurance Corporation, under form number BCBSD 4501, to allow for dependent coverage of Domestic Partners and their children, as specified below. Benefits under this Rider are subject to all the terms and conditions of the policy, unless otherwise stated herein.

GENERAL DEFINITIONS

DOMESTIC PARTNERS are two individuals who, together, each meet all of the following criteria:

1. At least 18 years of age or older.
2. Are competent to enter into a contract.
3. Are not legally married to, nor the domestic partner of, any other person.
4. Their partnership must not violate Wis. Stats. 765.03, which bars marriage between certain persons based on kinship and divorce.
5. They must consider themselves to be members of each other's immediate family.
6. They must agree to be responsible for each other's basic living expenses.
7. They share a common residence-any of the following conditions may apply:
 - a. Only one partner has legal ownership of the residence (if ownership is applicable).
 - b. One or both partners have additional residences not shared with the other partner.
 - c. One partner leaves the common residence with the intent to return.

ELIGIBILITY

Domestic Partners will be accepted for enrollment under the Plan only if they meet all of the applicable requirements above and the Employee and his/her Domestic Partner have registered as domestic partners using an Affidavit that is approved by the Employee's employer:

A. Criteria for Eligibility of Children of Domestic Partners

Children of the Employee's Domestic Partner will be subject to the same criteria that are listed for Dependents in the Eligibility section of the Participant booklet.

B. Application & Effective Date

Coverage for Domestic Partners and their children will be subject to the same effective dates listed for Dependents in the Eligibility section of the Participant booklet. In addition, the following provision applies:

Except during an open enrollment period, the Employee must submit an application to add the Domestic Partner within 30 days of the date of the Domestic Partner acknowledgement letter provided by either the Employer or the Department of Employee Trust Funds, whichever provides the earlier acknowledgement letter. If the Affidavit is in place and there is a subsequent qualifying event allowing a special enrollment opportunity, an application must be submitted within 30 days of the event.

TERMINATION

Domestic Partners and their children will be subject to the same provisions listed for Dependents in the Termination section of the Participant booklet. In addition, the following provision applies:

A. Coverage for the Domestic Partners and their Child(ren)

When there is a change in one or more of the qualifying conditions listed in the definition of Domestic Partner above:

1. The applicable Affidavit of Termination of Domestic Partnership must be filled out by the Employee within 30 days of the event.

2. Coverage will terminate the last day of the month in which the change occurred.

B. Continuation and Conversion Coverage

The Domestic Partner, and any dependent children covered under this policy will be subject to the same continuation and/or conversion provisions as specified in the Participant booklet. Failure to notify your Employer of a Dependent's loss of eligibility within 30 days of the event may mean that your Dependent will not be eligible to continue coverage.

GENERAL PROVISIONS

The Employee and Domestic Partner acknowledge that, in applying for this coverage, if false statements are made that cause Us to suffer any loss, We may bring civil action against either or both parties to recover Our losses, including attorney's fees.

The UW System Administration and DentalBlue do not discriminate on the basis of disability in the provision of programs, services, or employment. If you are disabled and need this printed information in a different form or if you need assistance in using our services please contact one of DentalBlue's Benefit Information or Customer Service offices.