CARE-PLUS TOTAL ACCESS
DENTAL PROGRAM
3333 N. MAYFAIR ROAD, SUITE 311
WAUWATOSA, WI 53222

CARE-PLUS DENTAL PLANS, INC.

DENTAL CARE GROUP POLICY

CERTIFICATE OF INSURANCE

under

ST. NORBERT COLLEGE
Group No. MW017
Issued by

CARE-PLUS Dental Plans, Inc.

PLAN ADMINISTRATOR: **St. Norbert College**
100 Grant Street
De Pere, WI 54115

EMPLOYER I.D. #: **39-1399196**

EFFECTIVE DATE: **January 1, 2020**

This certifies that CARE-PLUS Dental Plans, Inc. has issued and delivered to the Policyholder a Group Contract insuring certain Participants covered by the Contract. Provisions of the Group Contract are summarized in the Plan Benefit Schedule Addendum "A" and the Procedures Description Addendum "B", which are attached hereto and made a part of this certificate.

This individual certificate is furnished in accordance with and is subject to the terms of the Group Contract. An individual is covered under the policy only if the terms, provisions and conditions of the policy have been satisfied. The coverage described in the policy is available to a person and his or her dependents only if the person is eligible, has enrolled for coverage and the proper fees have been paid by the Policyholder.

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Rd., Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
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CarePlus Dental Plans

CARE-PLUS TOTAL ACCESS DENTAL PROGRAM

PLAN BENEFIT SUMMARY

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GROUP DENTISTS

Under the CARE-PLUS Total Access dental program, Participants can seek care from the Group Dentist of their choice. Benefits will be paid according to the tier status of the Group Dentist rendering services. Participants can obtain a list of participating Group Dentists by referring to the web site on their insurance card.

CARE-PLUS DENTAL PLANS, INC.
DENTAL CARE GROUP POLICY

INTRODUCTION

Welcome to the "CARE-PLUS Total Access" dental program. CARE-PLUS Dental Plans, Inc. ("CARE-PLUS") is a non-profit insurance company. CARE-PLUS was formed in 1983 to provide comprehensive dental care programs

Members of CARE-PLUS Total Access can receive Dental Services from the Group Dentist of their choice. CARE-PLUS Total Access is designed to encourage You to visit the dentist regularly. There are two tiers of Benefits offered through CARE-PLUS Total Access. Members can elect to see a Dental Associates, Ltd. of Wisconsin Group Dentist (Tier One) or a contracted Group Dentist from the PPO Network (Tier Two) to receive a discount on Dental Services and be eligible for higher Benefits.

Please take a few minutes to read through this Certificate so You may get a thorough understanding of Your Benefits and CARE-PLUS' policies and procedures.

This Certificate briefly summarizes the insurance Contract between CARE-PLUS and Your Group. The Master Group Contract governs the Benefits and limitations of Your coverage. You may review the Contract during normal business hours if You desire. Please call Your Group or CARE-PLUS.

QUALITY IMPROVEMENT
Summary

CARE-PLUS has established a quality improvement committee that identifies, evaluates and seeks to improve processes related to access to care and quality of care.

Through a series of project and process management activities, all staff members are involved with the implementation of our quality improvement initiatives. Additionally, Members play a vital role in improving the quality of care. Please bring any problems or complaints to our attention immediately.

RIGHTS AND RESPONSIBILITIES OF PARTICIPANTS

Participant Rights

Right To Choose
You have the right to choose the Group Dentist from which You will receive services from, with the understanding that Benefits may be paid differently depending on their tier status.

Right To Information
You have the right to information on Your dental plan relating to:

- Covered and excluded dental Benefits,
- Available general and specialty care providers and their tier status,
- Preventive care,
- Your condition and its related care,
- The process to make known a complaint or request, and
- Policies and procedures relevant to Your care.

Right To Privacy and Confidentiality
You have the right to privacy and confidentiality of all communications and records on Your care.

Right To Be Treated with Respect and Dignity
You have the right to be treated with respect and dignity regardless of Your race, age, sex or creed.

Right To Participate in Your Care
You have the right to be active in decisions about Your treatment. You have the right to a candid discussion of appropriate or dentally necessary treatment options for Your condition, regardless of cost or benefit coverage. You have the right to be informed about the risks and benefits of treatment and to refuse care.

Right To Present a Complaint or Grievance
You have the right to voice concerns about Your care and to receive a prompt and fair review of Your complaints. You have the right to courteous and attentive treatment.

Participant Responsibilities

You Must Know Your Benefits and Requirements
You have a responsibility to:

- Understand Your dental plan Benefits,
- Verify the tier status of Group Dentists prior to receiving treatment,
- Follow the required procedures, and
- Ask questions about things You do not understand.

You Must Provide Accurate Information
You have a responsibility to provide accurate and complete information about Your health and dental history and Your eligibility and enrollment. You have a responsibility to fulfill any financial obligations You may incur on the day You receive services.

You Should Participate in Your Care
You have a responsibility to participate in Your care by:

- Asking questions to understand Your condition;
- Following the recommended or agreed upon, treatment plan for Your condition; and
- Making healthy lifestyle choices to try to maintain Your oral health and prevent illness.

You Must Keep Your Appointments
You have a responsibility to keep Your appointments or to give early notice if You must reschedule or cancel an appointment or it will be considered a missed appointment.

You Must Show Consideration and Respect
You have a responsibility to show consideration and respect to health care providers and staff.

DEFINITIONS

When used and capitalized in this Certificate or any amendments or riders attached hereto, the terms listed below are defined as follows:

1. **Allowable Fee.** The Allowable Fee is the amount, under this Contract, paid to Group Dentists for covered Dental Services. Tier One and Tier Two Group Dentists have contractually agreed to accept the Allowable Fee as payment in full for covered Dental Services, with no additional billing to the Participant other than coinsurance and deductible amounts, unless the Participant has met their annual maximum benefit.

2. **Benefits**. Under the Contract, Benefits include the Dental Services as described in Addendum A and B of the Plan Benefit Schedule.

3. **Billed Amount.** The billed Amount is the amount that a Group Dentist bills or charges for covered Dental Services. Tier One and Two Group Dentists have contractually agreed not to bill Participants for the difference between the Billed Amount and the Allowable Fee for covered Dental Services.

4. **CARE-PLUS Dental Plans, Inc**. CARE-PLUS Dental Plans, Inc. is a Wisconsin corporation located in Milwaukee, Wisconsin. It will be referred to as CARE-PLUS in this Certificate.

5. **Contract**. The Contract is the agreement by CARE-PLUS to provide Benefits to the Group and includes the application You submitted to the Group and any supplements, amendments, endorsements or riders attached to the Contract.

6. **Dental Service**. Dental Service means those professional services of a Group Dentist, and the professional personnel or their agents who are associated with or employed by the dentist, which are generally and customarily prescribed except as expressly limited or excluded by the Contract.

7. **Effective Date**. Your Effective Date is the date on which You become covered for Benefits. You are eligible to receive treatment as of Your Effective Date.

8. **Emergency**. A serious dental condition caused by dental disease or accident that arises suddenly. If not treated immediately, an Emergency would result in jeopardy to Your dental health.

9. **Emergency Service.** The services described as Emergency Service in the Plan Benefit Schedule.

10. **Grievance**. Any dissatisfaction with CARE-PLUS, a Provider, the administration, claims practice or services provided under the Contract, expressed in writing by You or on Your behalf.

11. **Group.** The Group is the Employer or Fund through which You have this coverage.

12. **Group Dentist**. A Group Dentist means someone who is licensed as a Doctor of Dental Surgery or its equivalent, who is a professional practitioner authorized by law to practice dentistry and renders Dental Services under the Contract. Participants may obtain Dental Services from any Group Dentist offering such services. Participants are responsible for verifying the tier status of Group Dentists prior to receiving dental services.

13. **Laboratory Charges**. Laboratory Charges are any charges incurred by a Group Dentist or charged to the Group Dentist by a dental laboratory for the preparation and fabrication of space maintainers, all indirect restorations, prosthetic appliances, or the repair of the above.

14. **Member**. A Member is an employee (whether single or married) of the Group reported by the Group as eligible for Benefits under the Contract and for whom the proper fees have been paid.

15. **Out of Area Services**. Services rendered at a location outside the Service Area.

16. **Participant**. A Participant means any Member or his or her Dependents.

17. **Service Area**. The geographic area within a 50-mile radius of a Primary Provider location.

18. **Tier One Benefits**. Tier One Benefits are Benefits for Dental Services provided by a Group Dentist who is employed by Dental Associates, Ltd of Wisconsin and located at a Dental Associates, Ltd of Wisconsin facility. Participants can obtain a list of Dental Associates, Ltd of Wisconsin facilities by referring to the website on their insurance card. Generally, Tier One Benefits are the highest level of benefits and result in the lowest cost-sharing.

19. **Tier Two Benefits**. Tier Two Benefits are Benefits for Dental Services provided by a Group Dentist who is contracted by PPO Network, a CARE-PLUS network partner. CARE-PLUS has arranged with PPO Network to discount their charges for covered Dental Services. Participants can obtain a list of Tier Two Group Dentists by referring to the website on their insurance card.

20. **Tier Three Benefits**. **Not Applicable.** Tier Three Benefits are Benefits for Dental Services provided by a Group Dentist who is not employed by Dental Associates, Ltd of Wisconsin or contracted with the PPO Network. Generally, Participants are required to pay more for Tier Three Benefits than for Tier One or Tier Two.

21. **You**. The Member and his or her enrolled Dependents, unless specifically stated that "You" refers only to a Member or Dependent.

ELIGIBILITY

AN ELIGIBLE MEMBER IS:
An employee (whether single or married) of the Group who is reported by the Group as eligible for Benefits under the Contract.

A FAMILY DEPENDENT IS:
1. The Member's legal spouse.

2. The Member's children, including stepchildren, legally adopted children, and children placed for adoption with the Member, for whom the proper fees have been paid. A child placed for adoption shall be covered even if a court does not make a final order granting adoption; however, coverage will terminate if the child's adoptive placement with the Member terminates.

   A child ceases to be a Dependent on the day in which he or she attains the age of 26.

   In addition, if a child is unmarried and is 18 years of age or older and was a full-time student under the age of 27 at the time they were called to active duty in the reserves or national guard, they will remain eligible under the parent's plan beyond the age of 27 until they are no longer a full-time student.

   A child continues to be an eligible Dependent beyond the limiting age above if he or she is unable to support himself or herself, due to intellectual disability or physical handicap. CARE-PLUS reserves the right to require proof of disability as often as CARE-PLUS requests except, after the two year period immediately following the child's attainment of the limiting age, CARE-PLUS may request proof of continued disability no more than annually.

3. Any child of a Dependent child (the Member's grandchild) until the Dependent child reaches the age of 18.

4. The Member's children pursuant to a qualified medical child support order, as defined by the Omnibus Budget Reconciliation Act of 1993.

ENROLLMENT

INITIAL ENROLLMENT PERIOD: At the time the Group is initially enrolled, each Member shall complete a CARE-PLUS application form. The Effective Date for Members enrolled during the initial enrollment period is the date the Contract begins.

SUBSEQUENT ENROLLMENT PERIOD: Employees not participating under the Contract may enroll or existing Members may terminate their coverage only during a subsequent enrollment period.

NEW EMPLOYEES: New employees of the Group and their Dependents may enroll within thirty (30) days of the date the employee first becomes eligible for coverage, as defined by the Group. If the employee properly enrolls and the required premium is paid, the Effective Date for new employees and their Dependents is the first of the month following the date of eligibility. If the new employee declines coverage, (s)he may enroll at the next open enrollment period except in the case of an event that permits earlier enrollment. An employee who declines coverage because (s)he 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 employee must apply for such change in coverage within thirty (30) days of the event causing the loss of the other coverage.

NEW DEPENDENTS:

1. MARRIAGE. Dependents who become eligible due to marriage may enroll within thirty (30) days of the marriage date. If such Dependents are properly enrolled and the applicable premium is paid within such timeframe, the Effective Date for such Dependents is the date of the marriage.
2. NEWBORN CHILDREN. A Member's newborn child will be covered from the date of birth provided CARE-PLUS is notified of the birth and the Member pays the additional premium within sixty (60) days of the date of birth. Otherwise, the child may be enrolled within one year after the date of birth if the Member makes all past due payments of the applicable Premium.

   If no additional premium is required to enroll the child, the newborn child will be covered as of the date of birth. CARE-PLUS requests that the Member notify CARE-PLUS within sixty (60) days of the birth of the new Dependent.
3. ADOPTED CHILDREN. An adopted child or child placed with the Member for purposes of adoption will be covered from the date of the final decree of adoption or date of placement if any required premium is paid and the Plan is notified within sixty (60) days after the date of adoption or placement.

IDENTIFICATION CARDS: Initial and subsequent Members will receive an identification card in the form prescribed by CARE-PLUS.

CHANGES IN MEMBERSHIP STATUS: You should notify Your Group within thirty (30) days or as soon as possible of any change of address or in Your status resulting from marriage, divorce, separation or death, or within sixty (60) days of the addition of coverage of a newborn or adopted child.

BROKEN APPOINTMENTS

If You break an appointment without sufficient notice, as defined by the Group Dentist, the Group Dentist may charge a fee for the block of time reserved. This fee is not covered under the Contract.

BENEFITS

The Benefits available to You are the Dental Services and Emergency Service set forth in the attached Benefit Schedule and Procedure Description.

EXCLUSIONS AND LIMITATIONS

Benefits shall not include:

1. Dental Services not specifically described in the Contract as a Benefit.

2. Dental Services with respect to congenital malformations or that are primarily for cosmetic or esthetic purposes, except congenitally missing teeth.

3. Any duplicate prosthetic device or any other duplicate appliance, except as otherwise provided.

4. The replacement of a lost or stolen prosthetic device or appliance, except as otherwise provided.

5. The replacement of an orthodontic appliance, except as otherwise provided.

6. Treatment of temporomandibular joint (TMJ) dysfunction.

7. Gold foil, gold or precious metal restorations, except when used as necessary functional material.

8. Transplants.

9. Dental Service:

   (a) That are not consistent with and are not necessary, according to accepted standards of good dental practice, for the diagnosis and treatment;

   (b) That is performed primarily for cosmetic purposes;

   (c) That would be furnished, without charge, to You by any person or entity other than CARE-PLUS;

   (d) That You would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government;

   (e) That You are entitled or would be entitled if You were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if the Contract were not in effect;

   (f) To the extent that Medicare is Your primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no Benefits are available to the extent You would have been entitled to Medicare benefits had You enrolled in Medicare or complied with Medicare requirements;

   (g) For, or resulting from injuries, disease or conditions for which You receive, or are the subject of, any award or settlement under a Workers Compensation Act or any Employer Liability Law; or

   (h) Rendered or furnished after the date You cease to be covered under the Contract, unless your cessation of coverage is not due to a termination of the Contract, in which case coverage may

continue for You until the earlier of the date You are covered by an alternative dental policy or the date the Contract is no longer in force. Continued coverage is only available for:

(i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and

(ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following, termination of coverage.

10. Hospital or physician services of any kind whether or not related to covered Dental Services.

11. Dental Service and Emergency Service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of this Contract and caused by atomic explosion whether or not the result of war.

12. Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit shown in the Benefit Schedule.

13. Dental Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.

14. Replacement of an existing removable denture, full denture, crown or fixed bridge by a new removable partial denture, full denture, crown or a fixed bridge if the existing appliance was provided in the previous five years. The five-year period will be measured from the date on which the existing appliance was last supplied, whether under the Contract or under any other dental coverage.

15. If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the Participant selects a more complicated treatment (precision attachments or fixed bridgework), Benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the Participant.

16. Services or supplies for personalization or characterization of dentures or bridges.

17. Crowns to restore diseased or broken teeth when the tooth can be restored by a conventional type filling.

18. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

    a. Benefits are provided or payable under any Workers' Compensation, Employer Liability Law, or Occupational Disease Act or Law; or

    b. You would have been eligible for benefits under any Workers' Compensation, Employer Liability Law or Occupational Disease Act or Law had You applied for such coverage;

19. Any service related to:

    (a) Altering vertical dimension;

    (b) Restoration of occlusion;

    (c) Splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth;

(d) Replacing tooth structures as a result of abrasions, attrition, or erosion; or

(e) Bite registration or bite analysis.

20. Missed appointment charges.

21. Removal of asymptomatic third molars (wisdom teeth).

22. Procedures done in conjunction with fixed complex implant retainer prosthetics.

TERMINATION

1. **Termination by Group**. If the Contract terminates for any reason, Your rights to Benefits under the Contract shall terminate at the end of the period for which the last Fee Deposit was paid to CARE-PLUS.

2. **Termination of Member**. Your rights to Benefits under the Contract shall terminate at the end of the period for which the Group paid the last Fee Deposit to CARE-PLUS on Your behalf.

3. **Termination of Dependent**. A Dependent's rights to Benefits under the Contract shall automatically cease on the date in which he or she ceased to be a Dependent or at the end of the period for which the last Fee Deposit was paid to CARE-PLUS by the Group, if earlier.

4. **Service After Termination**. Except as otherwise provided in the Contract, if any services are required by You or a dependent or are performed on Your behalf after Your rights to Benefits have terminated, the expenses incurred for such care shall be Your full responsibility.

MEDICARE

Members aged 65 or older should go to their Personnel Office for a description of insurance options available to them.

Participants should go to the nearest area office of the Social Security Administration to enroll in Medicare three months before their 65th birthday, or if their doctor certifies they are disabled. Failure to enroll in Medicare may reduce the Benefits under the Contract. Please see the "Exclusions and Limitations" article.

DISENROLLMENT

CARE-PLUS may disenroll You, resulting in termination of coverage, for any one of the reasons described below:

1. You fail to pay required premiums within 31 days after the due date.

2. You permit someone else to use the enrollment identification or knowingly provide fraudulent information in applying for coverage or receiving services.

3. You pose a threat to providers or other Members of the plan because of physical or verbal abuse.

CLAIM RULES

1. **Definitions**.

"Post-service claim" is a claim for payment or reimbursement after receipt of care.

"Pre-Service Estimate" is a claim filed before receipt of care showing the services to be provided to a Participant for treatment costing $200.00 or more. Participants are encouraged to obtain pre-service estimates when using Tier Three Group Dentists to avoid any unnecessary reduction in benefits for non-covered services or services that are not dentally necessary. CARE-PLUS will evaluate the claim and notify the Group Dentist whether the requested services are covered under the Contract.

"Urgent care claim" is a claim where waiting the standard time for a benefit decision could seriously jeopardize a Participant's life, health or ability to regain maximum function or in the opinion of a physician with knowledge of the Participant's condition, would subject the Participant to severe pain that cannot be adequately managed without the care requested.

2. **Proof of Loss.** You must give Care-Plus written proof of a loss for which a claim is made. This proof must cover the occurrence, character and extent of the loss. You must furnish proof within ninety (90) days after the date of the loss, otherwise the claim will not be considered valid. However, if it is not reasonably possible to meet such time limit, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

3. **Initial Determinations**.

a. Initial determinations will be made within the following timeframes.

(1) Pre-service claims: Within a reasonable amount of time appropriate to the medical circumstances but not later than sixty (60) days after the date the claim was received.

(2) Post-service claims: Within a reasonable period of time, but not later than thirty (30) days after the date the claim was received.

If Care-Plus determines that we will not be able to meet the above deadline, for reasons beyond our control, we will notify You in writing prior to the expiration of the initial deadline. The notice will state the reason for the delay and the date on which You can expect a decision. The expected decision date will not be more than fifteen (15) days from the original deadline. However, if we require additional information from You to make the benefit determination, the expected decision date will be not more than fifteen (15) days from the date You respond to the request for additional information. The notice will specifically describe the additional information required. You will have forty-five (45) days from the date You receive the notice to provide the additional information.

b. Claim Denials.

If we deny Your claim, in whole or in part, we will inform You in writing. The denial notice will include all of the following:

(1) The specific reason(s) for the denial.

(2) Reference to the specific plan provision on which the denial is based.

(3) A description of any additional information needed to complete the claim and an explanation of why the information is necessary.

(4) A description of Your right to appeal, including the deadline and procedures, and Your right to bring a civil action under the Employee Retirement Security Income Act of 1974, as amended, ("ERISA") section 502(a) if the appeal is not decided in Your favor.

(5) If we used a specific internal guideline to make our determination, a statement that we relied on such guideline and that You may obtain a copy of the guideline free of charge, upon request.

(6) If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

(7) If Your claim involves urgent care, a description of our expedited review process.

c. Appeal of Claim Denials. You have one hundred eighty (180) days after You receive a notice described in part b above to appeal a claim denial. You appeal a claim denial by following the Grievance Procedure explained below.

Grievance Procedure.

You will be notified of Your right to file a Grievance and the procedure to follow each time a claim or benefit is denied. This includes a refusal to refer You for additional services, or when disenrollment proceedings are initiated. The notification will state the specific reason for the denial or initiation of disenrollment proceedings. The Grievance procedure is outlined below.

In the event that You have a complaint or problem regarding services under the Contract, You should submit Your Grievance in written form to CARE-PLUS' Grievance committee. The Grievance committee will acknowledge the Grievance in writing within five (5) business days of receipt.

If Your Grievance is an appeal of an urgent care claim, You may request an expedited Grievance. You should call 1-414-771-1711 or 1-800-318-7007 and state that You would like an expedited Grievance.

You have the following rights with respect to Your Grievance:

a. The right to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

b. The right to submit written comments, documents, records and other information relating to Your claim.

c. The right to appear before the Grievance committee to present written or oral information and to question the person who made the initial determination that resulted in the Grievance. The Grievance committee shall notify You of the date and time of the committee meeting at least seven (7) calendar days before the meeting is scheduled.

The Grievance committee will conduct a complete, new review of Your claim, without considering the initial determination. The committee will not include the person who originally denied the claim or that person's subordinate. If the claim requires a medical judgment, the committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. If a health care professional was consulted in making the initial determination, the health care professional consulted on appeal will not be the same person or that person's subordinate. Upon request, we will provide You with the names of the medical or vocational experts consulted to reach a determination.

The Grievance committee will provide You with a written decision within the following timeframes:

a. Urgent care claim: As quickly as Your condition requires, but no later than within seventy-two (72) hours of receipt of the Grievance. If Care-Plus denies the claim and communicates the denial to You orally, You will receive a written notice within three days.

b. Pre-service estimate: Within thirty (30) days of the date we originally received the Grievance.

c. Post-service claim: Within thirty (30) days of the date we originally received the Grievance.

The committee's written decision will notify You of the result of Your Grievance and any corrective action taken. The decision will be signed by a member of the committee and include the position titles of the committee members.

If the Grievance committee denies Your appeal, in whole or in part, the written decision will include all of the following:

a. The specific reason(s) for the denial.

b. Reference to the specific plan provision on which the denial is based.

c. A statement that You are entitled to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

d. A statement of Your right to bring a civil action under ERISA section 502(a).

e. If the Grievance committee used a specific internal guideline to make the determination, a statement that it relied on such guideline and that You may obtain a copy of such guideline free of charge, upon request.

f. If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

You may resolve the Grievance by taking the steps outlined above. You also may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that 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
P.O. Box 7873
Madison, WI 53707-7873

Or You can call 800-236-8517 outside of Madison or 608-266-0103 in Madison, and request a complaint form.

Authorized Representative.

Your authorized representative may act on Your behalf in pursuing a claim or Grievance. Unless one of the exceptions listed below applies, You must submit a statement in writing that the representative is authorized to act on Your behalf and may receive Your confidential information. We have a form available that You may use to appoint an individual as Your authorized representative.

We will not require written authorization if any of the following applies:

a. The person is authorized by law to act on Your behalf.

b. You are unable to give consent and the person is a spouse, family member or the treating provider.

c. The Grievance is an expedited Grievance and the person represents that You have verbally authorized the person to represent You.

GENERAL CONDITIONS

1. **Dentist/Participant Relationship**. Nothing in the Contract shall interfere with the professional relationship between You and Your attending Dentist.

2. **Evidence of Participation**. You must present Your identification card, or otherwise make the fact of Your participation known, to the Group Dentist when seeking Covered Dental Benefits.

3. **Release of Information**. You expressly consent to, authorize and direct any Group Dentist or other person or corporation by whom or in which dental, medical or surgical treatment is being considered or has been rendered, to release any records or other information, or copies thereof, as CARE-PLUS may request.

4. **Subrogation**. Whenever CARE-PLUS has been or is providing Benefits because of an injury or sickness for which a third party may be liable, CARE-PLUS may make a claim or maintain an action against the third party for damages, reimbursement or payment to the extent of the value of Benefits received or to be received.

   By accepting Benefits from CARE-PLUS relating to an injury or sickness, You assign to CARE-PLUS the right to make a claim against the third party to the extent of the value of Benefits rendered.

   You and CARE-PLUS agree to join the other in making a claim against the third party or commencing an action.

   To the extent required by law, CARE-PLUS shall seek to recover proceeds from You only after You have been wholly or fully compensated for the damages arising from the injury or sickness. CARE-PLUS shall have an equitable lien that shall attach to any recovery to the extent of its subrogation rights. You shall hold in trust for CARE-PLUS any proceeds recovered to the extent of its subrogation rights.

   You must not do anything after the loss to prejudice any rights of CARE-PLUS or of the Group to recovery. You must promptly advise CARE-PLUS and the Group in writing whenever a claim against a third party is made with respect to any loss for which Benefits were, or are being, received from CARE-PLUS.

   Nothing contained in this section shall limit the ability or right of the Group to make a claim or maintain an action against the third party for recovery.

5. **Non-Assignment of Benefits**. No person other than You is entitled to Benefits under this Contract. Rights under this Contract are not assignable or transferable in any manner. Rights shall be forfeited if You or any other person assigns, transfers or aids any other person improperly in obtaining Benefits hereunder.

6. **Limitation of Actions**. You may not start an action or suit, at law or in equity, to recover Benefits under the Contract until at least sixty (60) days after a claim has been filed with CARE-PLUS in writing or CARE-PLUS denies the claim, whichever is earlier. No action shall be commenced more than three years from the time the written proof of loss is required to be furnished to CARE-PLUS.

7. **Obligation of CARE-PLUS**. CARE-PLUS shall in no way be responsible for any act or omission of any Provider, Group Dentist, professional practitioner or their agents, to supply Dental Services. The obligation of CARE-PLUS shall be limited solely to providing Benefits according to the provisions in the Contract.

8. **Reimbursement**. You agree to reimburse CARE-PLUS for any Benefits paid or provided for which You were not eligible under the terms of the Contract. Such reimbursement shall be due and payable immediately upon notification and demand to You by CARE-PLUS.

9. **Misrepresentations**. Fraudulent misstatements by You shall void Your coverage and serve as the basis for denials of claims for Benefits.

10. **Dual Coverage**. If You are eligible for Benefits under more than one CARE-PLUS Contract, You shall be entitled to an allowance therefore equal to the Allowable Fee for the aggregate Benefits available under such CARE-PLUS Contracts, up to, but not exceeding, the total Billed Amount for all dental Services.

COORDINATION OF BENEFITS

1. APPLICABILITY. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan. However, this provision may be 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 shall be 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:

   a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the section "Effect on the Benefits of This Plan."

2. DEFINITIONS.

   a. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care. Allowable Expense includes Dental Services and Orthodontic Services, when the item of expense is covered at least in part by one or more Plans covering the claimant. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

   b. "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.

   c. "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. 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. 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.

d. "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.

e. "This Plan" means the part of the Group Contract that provides Benefits for dental service expenses.

3. ORDER OF BENEFIT DETERMINATION. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its Benefits determined after those of the other Plan, unless:

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

b. Both those rules and This Plan's rules described below require that This Plan's Benefits be determined before those of the other Plan.

4. RULES. This Plan determines its order of benefits using the first of the following rules that applies:

a. Non-dependent/Dependent. The benefits of the Plan that covers the person other than as a Dependent are determined before those of the Plan that covers the person as a Dependent.

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

(1) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (1) 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.

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

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) 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 b. above.

However, if the specific terms of a court decree state that one parent 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.

d. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan that 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 d. is ignored.

e. Continuation Coverage. 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 person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

(2) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. 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 that covered that person for the shorter time.

5. EFFECT ON THE BENEFITS OF THIS PLAN.

a. When This Section Applies. This Section applies when, in accordance with the Section "Order of Benefit Determination", 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 as "the other Plans" below.

b. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(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. Under this provision, 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.

6. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. CARE-PLUS has the right to decide the facts it needs to apply these COB rules. It 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 records remain confidential as provided by state law. Each person claiming Benefits under This Plan must give CARE-PLUS any facts it needs to pay the claim.

7. FACILITY OF PAYMENT. A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, CARE-PLUS may pay that amount to the organization that made that payment. That amount will then be treated as though it was a Benefit paid under This Plan. CARE-PLUS 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.

8. RIGHT OF RECOVERY. If the amount of the payments made by CARE-PLUS is more than it should have paid under this COB provision, it may recover the excess from one or more of:

   a. The persons it has paid or for whom it has paid;

   b. Insurance companies; or

   c. Other organizations.

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

For further information, contact:

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Rd., Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
(800) 318-7007

ADDENDUM A
PLAN BENEFIT SCHEDULE
FOR
ST. NORBERT COLLEGE
GROUP NO. MW017

1. COVERED DENTAL SERVICES.
Except as otherwise specified in this Contract, Participants are entitled to any of the Dental Services listed that begin on or after their Effective Date of coverage. Such Dental Services are to be consistent with and necessary, according to accepted standards of good dental practice, for the diagnosis and treatment of the Participant and must not be performed primarily for cosmetic purposes.

2. DENTAL PROVIDERS. Participants may obtain covered Dental Services from any Group Dentist offering such services. Generally, Tier One Benefits, provided by a Group Dentist employed by Dental Associates, Ltd of Wisconsin and at a Dental Associates, Ltd of Wisconsin facility, are the highest level of benefits and result in the lowest cost sharing. Tier One and Tier Two Group Dentists are under contract with CARE-PLUS and have agreed to accept the Allowable Fee with no additional billing to the Participant other than coinsurance and deductible amounts, unless the Participant has met their Annual Maximum Benefit. Participants are responsible for verifying the network status of Group Dentists prior to receiving dental services. Participants can obtain a list of Tier One and Tier Two Group Dentists by referring to the website on their insurance card.

3. ANNUAL MAXIMUM BENEFITS. The Annual Maximum Benefit for Dental Services, except orthodontic services, is

a. Tier One, $1,250.00 per eligible Participant.
b. Tier Two, $1,250.00 per eligible Participant.
c. Tier Three, N/A per eligible Participant.

The Annual Maximum Benefit, Policy Deductible and co-insurance are applied to each claim based on the tier status of the Group Dentist providing Dental Services. The value of Benefits received under all tiers are added together to determine if the Annual Maximum Benefit is met. Under no circumstances, is a Participant eligible to receive Benefits in excess of the Tier One Annual Maximum Benefit.

4. POLICY DEDUCTIBLE. The annual deductible amount is

a. Tier One, Subject to an annual deductible amount of $N/A per eligible Participant.
b. Tier Two, Subject to an annual deductible amount of $N/A per eligible Participant.
c. Tier Three, Subject to an annual deductible amount of $N/A per eligible Participant.

The value(s) of the deductible applied to Benefits received under all tiers are added together to determine if the Policy Deductible is met.

5. DIAGNOSTIC AND PREVENTIVE SERVICES. Benefits for diagnostic and preventive services shall not be applied towards the Participant's Annual Maximum Benefit (Tier One only).

6. ORTHODONTIC SERVICES. Benefits for a complete routine orthodontic case shall:

a. Be available to eligible Participants to age 26;

b. Be subject to a copayments as follows:

Tier One, Be subject to a copayment of 50% of the Group Dentist's fees to be paid by the Participant.
Tier Two, Be subject to a copayment of 50% of the Group Dentist's fees to be paid by the Participant.
Tier Three, Be subject to a copayment of N/A of the Group Dentist's fees to be paid by the Participant.

c. Be subject to lifetime maximum benefits as follows:

Tier One, Be subject to a lifetime maximum benefit of $1,500.00.
Tier Two, Be subject to a lifetime maximum benefit of $1,500.00.
Tier Three, Be subject to a lifetime maximum benefit of $N/A.

d. Be subject to a deductible amount as follows:

Tier One, N/A per eligible Participant.
Tier Two, N/A per eligible Participant.
Tier Three, N/A per eligible Participant.

A routine orthodontic case is one in which alignment of the teeth is accomplished using a single phase of treatment with complete braces and a single set of retainers. Additional costs are incurred when treatment requires auxiliary fixed or removable appliance therapy, such as the use of functional jaw orthopedic appliances; treatment of impacted teeth/tooth; cleft palate; orthognathic surgery procedures; or use of ceramic braces or other specialized braces other than stainless steel that the patient may require or request for specific reasons.

Each Participant eligible under a. shall be entitled to one complete course of orthodontic treatment while the Contract is in force.

Orthodontic Benefits including surgical and appliance therapy will only be provided when, in the opinion of the orthodontist, treatment is necessary, and a satisfactory result can be achieved.

Orthodontic benefits will terminate when a Participant ceases to be eligible for coverage, i.e. age limitations for orthodontic treatment or termination of the Contract by the Group or CARE-PLUS for any reason.

Cross bite in permanent teeth will only be treated when, in the opinion of the orthodontist, other conditions are present that would indicate that orthodontic treatment is necessary.

If the orthodontic treatment is terminated for any reason before completion, the obligation of CARE-PLUS to provide Benefits shall cease as of such date of termination. If such orthodontic treatment is resumed, Benefits shall resume, to the extent remaining under this Contract.

7. LABORATORY CHARGES. Except as otherwise provided, the Participant will not be liable for Laboratory Charges.

8. EMERGENCY SERVICE. Emergency Service includes Dental Service that is required immediately as a result of an accident or Emergency illness. Emergency Service does not include Dental Service for elective care or care required as a result of circumstances or conditions that could be reasonably have been foreseen.

a. There will be a Group Dentist on call for non-clinic hours to attend to the Participant’s Emergency needs within the Service Area (Tier One only).

b. Participants who receive Emergency Service outside the Service Area, shall be entitled

to Benefits for Dental Service not to exceed the lesser of the Charges directly related to Emergency Service or $150.00 per Participant (the maximum allowance). Proof of Emergency Service must be given to CARE-PLUS within thirty (30) days of date of occurrence.

9. EVIDENCE-BASED BENEFITS. When provided by a Tier One (or Two) Group Dentist, Participants are eligible for the following benefits for evidence-based integrated care:

1. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year following periodontal surgery.

2. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for diabetics.

3. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to one time per benefit year during pregnancy.

4. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for patients with any of the following high–risk cardiac conditions.
   a. History of infective endocarditis.
   b. Certain congenital heart defects (e.g., having one ventricle instead of two).
   c. Artificial heart valves.
   d. Heart-valve defects caused by acquired conditions like rheumatic heart disease.
   e. Hypertrophic cardiomyopathy, which causes abnormal thickening of the heart muscle.
   f. Individuals with pulmonary shunts or conduits.
   g. Mitral-valve prolapse with regurgitation (blood leakage).

5. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for suppressed-immune-system conditions.

6. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for kidney failure or dialysis conditions.

7. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for cancer-related chemotherapy and/or radiation treatments.

10. DENTAL SERVICES PROVIDED TO THE GROUP. See Addendum B

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ST. NORBERT COLLEGE, GROUP NO. MW017

Benefits include the following dental services unless specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	CO-PAYMENT TIER1	CO-PAYMENT TIER 2	CO-PAYMENT TIER 3
D0120	Periodic oral examination – 2 per year –frequency rules apply	NONE	NONE	N/A
D0140	Limited oral evaluation – problem focus	NONE	NONE	N/A
D0145	Oral evaluation for patient <3 years w/counseling w/primary caregiver – frequency rules apply	NONE	NONE	N/A
D0150	Comprehensive oral evaluation – frequency rules apply	NONE	NONE	N/A
D0160	Detailed and extensive oral evaluation – problem focused, by report	NONE	NONE	N/A
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	NONE	NONE	N/A
D0171	Re-evaluation – post-operative visit	NONE	NONE	N/A
D0180	Comprehensive periodontal evaluation – new or established patient – frequency rules apply	NONE	NONE	N/A
D0210	Intra oral complete series of radiographic images w/bitewings	NONE	NONE	N/A
D0220	Intra oral periapical first radiographic image	NONE	NONE	N/A
D0230	Intra oral periapical each additional radiographic image	NONE	NONE	N/A
D0240	Intraoral – occlusal radiographic image	NONE	NONE	N/A
D0270	Bitewing single radiographic image	NONE	NONE	N/A
D0272	Bitewing two radiographic images – 2 per year	NONE	NONE	N/A
D0273	Bitewing – three radiographic images – 2 per year	NONE	NONE	N/A
D0274	Bitewing-four radiographic images – 2 per year	NONE	NONE	N/A
D0277	Vertical bitewings – 7 to 8 radiographic images – 2 per year	NONE	NONE	N/A
D0330	Panoramic radiographic image	NONE	NONE	N/A
D0460	Pulp vitality tests	NONE	NONE	N/A
D0470	Diagnostic casts	NONE	NONE	N/A
PREVENTIVE				
D1110	Prophylaxis adult – 2 per year	NONE	NONE	N/A
D1120	Prophylaxis child – 2 per year	NONE	NONE	N/A
D1206	Topical application of fluoride varnish – thru age 15	NONE	NONE	N/A
D1208	Topical application of fluoride – excluding varnish – thru age 15	NONE	NONE	N/A
D1310	Nutritional counseling for control of dental disease	NONE	NONE	N/A
D1330	Oral hygiene instructions	NONE	NONE	N/A
D1351	Sealant per tooth – thru age 15	NONE	NONE	N/A
D1353	Sealant repair – per tooth – thru age 15	NONE	NONE	N/A
D1354	Interim caries arresting medicament application – thru age 12	NONE	NONE	N/A
D1510	Space maintainer – fixed – unilateral	NONE	NONE	N/A
D1516	Space maintainer – fixed – bilateral, maxillary	NONE	NONE	N/A
D1517	Space maintainer – fixed – bilateral, mandibular	NONE	NONE	N/A
D1550	Re-cement/re-bond space maintainer	NONE	NONE	N/A

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ST. NORBERT COLLEGE, GROUP NO. MW017

Benefits include the following dental services unless specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	CO-PAYMENT TIER1	CO-PAYMENT TIER 2	CO-PAYMENT TIER 3
D1575	Distal shoe space maintainer – fixed – unilateral	NONE	NONE	N/A
RESTORATIVE				
D2140	Amalgam – one surface, primary or permanent	NONE	NONE	N/A
D2150	Amalgam – two surfaces, primary or permanent	NONE	NONE	N/A
D2160	Amalgam – three surfaces, primary or permanent	NONE	NONE	N/A
D2161	Amalgam – four or more surfaces, primary or permanent	NONE	NONE	N/A
D2330	Resin-based composite – one surface, anterior	NONE	NONE	N/A
D2331	Resin-based composite – two surfaces, anterior	NONE	NONE	N/A
D2332	Resin-based composite – three surfaces, anterior	NONE	NONE	N/A
D2335	Resin-based composite – four or more surfaces, anterior incisal angle	NONE	NONE	N/A
D2390	Resin-based composite crown, anterior	NONE	NONE	N/A
D2391	Resin-based composite – one surface, posterior	NONE	NONE	N/A
D2392	Resin-based composite – two surfaces, posterior	NONE	NONE	N/A
D2393	Resin-based composite – three surfaces, posterior	NONE	NONE	N/A
D2394	Resin-based composite – four or more surfaces, posterior	NONE	NONE	N/A
D2740	Crown – porcelain/ceramic substrate	10%	10%	N/A
D2752	Crown – porcelain fused to noble metal	10%	10%	N/A
D2792	Crown – full cast noble metal	10%	10%	N/A
D2910	Re-cement or re-bond inlay, onlay, veneer	10%	10%	N/A
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	10%	10%	N/A
D2920	Re-cement or re-bond crown	10%	10%	N/A
D2921	Reattachment of tooth fragment – incisal edge/cusp	NONE	NONE	N/A
D2929	Prefabricated porcelain/ceramic crown – primary tooth	10%	10%	N/A
D2930	Prefabricated stainless steel crown – primary tooth	10%	10%	N/A
D2931	Prefabricated stainless steel crown – permanent tooth	10%	10%	N/A
D2932	Prefabricated resin crown	10%	10%	N/A
D2933	Prefabricated stainless steel crown w/resin window	10%	10%	N/A
D2934	Prefabricated esthetic coasted stainless steel crown – primary tooth	10%	10%	N/A
D2940	Protective restoration	NONE	NONE	N/A
D2949	Restorative foundation for an indirect restoration	NONE	NONE	N/A
D2950	Core buildup including pins when required	10%	10%	N/A
D2951	Pin retention/tooth in addition to restoration	NONE	NONE	N/A
D2952	Post and core in addition to crown indirectly fabricated	10%	10%	N/A
D2953	Each additional indirectly fabricated post – same tooth (use with 2952)	10%	10%	N/A
D2954	Prefabricated post and core in addition to crown	10%	10%	N/A

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ST. NORBERT COLLEGE, GROUP NO. MW017

Benefits include the following dental services unless specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	CO-PAYMENT TIER1	CO-PAYMENT TIER 2	CO-PAYMENT TIER 3
D2955	Post removal	NONE	NONE	N/A
D2957	Each additional indirectly fabricated post – same tooth (use with 2954)	10%	10%	N/A
D2960	Labial veneer resin (laminate) chairside	10%	10%	N/A
D2980	Crown repair necessitated by restorative material failure	10%	10%	N/A
ENDODONTICS				
D3110	Pulp cap – direct excluding final restoration	10%	10%	N/A
D3120	Pulp cap – indirect excluding final restoration	10%	10%	N/A
D3220	Therapeutic pulpotomy excluding final restoration	10%	10%	N/A
D3221	Pulpal debridement, primary and permanent tooth	10%	10%	N/A
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development	10%	10%	N/A
D3230	Pulpal therapy, anterior primary tooth	10%	10%	N/A
D3240	Pulpal therapy, posterior primary tooth	10%	10%	N/A
D3310	Endodontic therapy anterior tooth	10%	10%	N/A
D3320	Endodontic therapy bicuspid tooth	10%	10%	N/A
D3330	Endodontic therapy molar tooth	10%	10%	N/A
D3332	Incomplete endodontic therapy procedure	10%	10%	N/A
D3346	Retreatment of previous root canal – anterior	10%	10%	N/A
D3347	Retreatment of previous root canal – bicuspid	10%	10%	N/A
D3348	Retreatment of previous root canal – molar	10%	10%	N/A
D3351	Apexification/recalcification – initial visit. If over age 11 no benefit if performed within 12 months of root canal.	10%	10%	N/A
D3352	Apexification/recalcification – interim medication replacement. If over age 11 no benefit if performed within 12 months of root canal.	10%	10%	N/A
D3353	Apexification/recalcification – final visit. If over age 11 no benefit if performed within 12 months of root canal.	10%	10%	N/A
D3410	Apicoectomy – anterior	10%	10%	N/A
D3421	Apicoectomy – bicuspid (first root)	10%	10%	N/A
D3425	Apicoectomy – molar (first root)	10%	10%	N/A
D3426	Apicoectomy (each additional root)	10%	10%	N/A
D3427	Periradicular surgery without apicoectomy	10%	10%	N/A
D3430	Retrograde filling – per root	10%	10%	N/A
D3450	Root amputation – per root	10%	10%	N/A
D3920	Hemisection not including root canal therapy	10%	10%	N/A
D3950	Canal preparation and fitting of preformed dowel or post	10%	10%	N/A
PERIODONTICS				
D4210	Gingivectomy/gingivoplasty/four or more teeth per quadrant	10%	10%	N/A

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ST. NORBERT COLLEGE, GROUP NO. MW017

Benefits include the following dental services unless specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	CO-PAYMENT TIER1	CO-PAYMENT TIER 2	CO-PAYMENT TIER 3
D4211	Gingivectomy/gingivoplasty/one to three teeth per quadrant	10%	10%	N/A
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	10%	10%	N/A
D4231	Anatomical crown exposure – one to three teeth per quadrant	10%	10%	N/A
D4240	Gingival flap procedure w/root plan/four or more teeth per quadrant	10%	10%	N/A
D4241	Gingival flap procedure w/root plan/one to three teeth per quadrant	10%	10%	N/A
D4249	Clinical crown lengthening – hard tissue	10%	10%	N/A
D4260	Osseous surgery – four or more teeth per quadrant	10%	10%	N/A
D4261	Osseous surgery – one to three teeth per quadrant	10%	10%	N/A
D4263	Bone replacement graft – first site in quadrant	10%	10%	N/A
D4264	Bone replacement graft – each additional site in quadrant	10%	10%	N/A
D4266	Guided tissue regeneration – resorbable barrier, per site	10%	10%	N/A
D4267	Guided tissue regeneration – nonresorbable barrier, per site	10%	10%	N/A
D4270	Pedicle soft tissue graft procedure	10%	10%	N/A
D4273	Subepithelial connective tissue graft procedures, per tooth	10%	10%	N/A
D4274	Distal or proximal wedge procedure	10%	10%	N/A
D4275	Soft tissue allograft	10%	10%	N/A
D4276	Combined connective tissue and double pedicle graft, per tooth	10%	10%	N/A
D4277	Free soft tissue graft procedure first tooth position	10%	10%	N/A
D4278	Free soft tissue graft procedure each additional tooth position	10%	10%	N/A
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	10%	10%	N/A
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	10%	10%	N/A
D4320	Provisional splinting – intracoronal	10%	10%	N/A
D4321	Provisional splinting – extracoronal	10%	10%	N/A
D4341	Scaling and root planing/four or more teeth per quadrant – one per 24 mo.	10%	10%	N/A
D4342	Scaling and root planing/one to three teeth per quadrant – one per 24 mo.	10%	10%	N/A
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation – one per 18 mo.	10%	10%	N/A
D4355	Full mouth debridement – one per 18 mo.	10%	10%	N/A
D4381	Localized delivery of chemo agents	10%	10%	N/A
D4910	Periodontal maintenance procedure – one per 12 mo. only	10%	10%	N/A
PROSTHODONTICS, REMOVABLE				
D5110	Complete denture – maxillary	10%	10%	N/A

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ST. NORBERT COLLEGE, GROUP NO. MW017

Benefits include the following dental services unless specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	CO-PAYMENT TIER1	CO-PAYMENT TIER 2	CO-PAYMENT TIER 3
D5120	Complete denture – mandibular	10%	10%	N/A
D5130	Immediate denture – maxillary	10%	10%	N/A
D5140	Immediate denture – mandibular	10%	10%	N/A
D5211	Maxillary partial denture – resin base	10%	10%	N/A
D5212	Mandibular partial denture – resin base	10%	10%	N/A
D5213	Maxillary partial denture – cast metal frame	10%	10%	N/A
D5214	Mandibular partial denture – cast metal frame	10%	10%	N/A
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	10%	10%	N/A
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	10%	10%	N/A
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	10%	10%	N/A
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	10%	10%	N/A
D5225	Maxillary partial denture – flexible base	10%	10%	N/A
D5226	Mandibular partial denture – flexible base	10%	10%	N/A
D5282	Removable unilateral partial denture one piece cast metal (including clasps and teeth), maxillary	10%	10%	N/A
D5283	Removable unilateral partial denture one piece cast metal (including clasps and teeth), mandibular	10%	10%	N/A
D5410	Adjust complete denture – maxillary	10%	10%	N/A
D5411	Adjust complete denture – mandibular	10%	10%	N/A
D5421	Adjust partial denture – maxillary	10%	10%	N/A
D5422	Adjust partial denture – mandibular	10%	10%	N/A
D5511	Repair broken complete denture base, mandibular	10%	10%	N/A
D5512	Repair broken complete denture base, maxillary	10%	10%	N/A
D5520	Replace missing/broken teeth – complete denture each tooth	10%	10%	N/A
D5611	Repair resin partial denture base, mandibular	10%	10%	N/A
D5612	Repair resin partial denture base, maxillary	10%	10%	N/A
D5621	Repair cast partial framework, mandibular	10%	10%	N/A
D5622	Repair cast partial framework, maxillary	10%	10%	N/A
D5630	Repair or replace broken clasp	10%	10%	N/A
D5640	Replace broken teeth – per tooth	10%	10%	N/A
D5650	Add tooth to existing partial denture	10%	10%	N/A
D5660	Add clasp to existing partial denture	10%	10%	N/A
D5730	Reline complete maxillary denture (chairside)	10%	10%	N/A
D5731	Reline complete mandibular denture (chairside)	10%	10%	N/A
D5740	Reline maxillary partial denture (chairside)	10%	10%	N/A
D5741	Reline mandibular partial denture (chairside)	10%	10%	N/A

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D5750	Reline complete maxillary denture (lab)	10%	10%	N/A
D5751	Reline complete mandibular denture (lab)	10%	10%	N/A
D5760	Reline maxillary partial denture (lab)	10%	10%	N/A
D5761	Reline mandibular partial denture (lab)	10%	10%	N/A
D5850	Tissue conditioning, maxillary	10%	10%	N/A
D5851	Tissue conditioning, mandibular	10%	10%	N/A
D5876	Add metal substructure to acrylic full denture (per arch)	10%	10%	N/A
D5899	CU-SEL attachment	10%	10%	N/A
D5899	Silicone soft liner	10%	10%	N/A
PROSTHODONTICS, FIXED				
D6212	Pontic – cast noble metal	10%	10%	N/A
D6242	Pontic – porcelain fused to noble metal	10%	10%	N/A
D6245	Pontic – porcelain/ceramic	10%	10%	N/A
D6740	Crown – porcelain/ceramic	10%	10%	N/A
D6752	Crown – porcelain fused to noble metal	10%	10%	N/A
D6792	Crown – full cast noble metal	10%	10%	N/A
D6930	Re-cement or re-bond fixed partial denture	10%	10%	N/A
D6940	Stress breaker	10%	10%	N/A
D6980	Fixed partial denture repair necessitated by material failure	10%	10%	N/A
IMPLANTS				
D6010	Surgical placement – endosteal , as indicated in article VII, procedures done in conjunction with fixed complex implant retainer prosthetics are not included	10%	10%	N/A
D6013	Surgical placement of mini implant	10%	10%	N/A
D6054	Implant abutment supported removal partial	10%	10%	N/A
D6056	Prefabricated abutment	10%	10%	N/A
D6057	Custom fabricated abutment	10%	10%	N/A
D6058	Abutment supported porcelain/ceramic crown	10%	10%	N/A
D6061	Abutment supported porcelain fused to metal crown (noble metal)	10%	10%	N/A
D6064	Abutment supported cast metal crown (noble metal)	10%	10%	N/A
D6065	Implant supported porcelain/ceramic crown	10%	10%	N/A
D6068	Abutment supported retainer for porcelain/ceramic fpd	10%	10%	N/A
D6071	Abutment supported retainer for porcelain fused to metal fpd (noble metal)	10%	10%	N/A
D6074	Abutment supported retainer for cast metal fpd (noble metal)	10%	10%	N/A
D6075	Implant supported retainer for ceramic fpd	10%	10%	N/A

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D6080	Implant maintenance procedures	10%	10%	N/A
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	10%	10%	N/A
D6085	Provisional Implant Crown	10%	10%	N/A
D6092	Re-cement or re-bond implant/abutment supported crown	10%	10%	N/A
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	10%	10%	N/A
D6096	Remove broken implant retaining screw	10%	10%	N/A
D6100	Implant removal, by report	10%	10%	N/A
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	10%	10%	N/A
D6111	Implant abutment supported removable denture for edentulous arch-mandibular	10%	10%	N/A
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	10%	10%	N/A
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	10%	10%	N/A
ORAL SURGERY				
D7111	Extraction, coronal remnants – deciduous tooth	NONE	NONE	N/A
D7140	Extraction, erupted tooth or exposed root	NONE	NONE	N/A
D7210	Surgical removal of erupted tooth	10%	10%	N/A
D7220	Removal of impacted tooth – soft tissue	10%	10%	N/A
D7230	Removal of impacted tooth – partial bony	10%	10%	N/A
D7240	Removal of impacted tooth – complete bony	10%	10%	N/A
D7241	Removal of impacted tooth – complete bony w/unusual surg. complications	10%	10%	N/A
D7250	Surgical removal of residual tooth roots	10%	10%	N/A
D7260	Oroantral fistula closure	10%	10%	N/A
D7270	Tooth reimplantation and/or stabilization	10%	10%	N/A
D7280	Surgical access of an unerupted tooth	10%	10%	N/A
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	10%	10%	N/A
D7283	Placement of device to facilitate eruption of impacted tooth	10%	10%	N/A
D7285	Incisional biopsy of oral tissue – hard	10%	10%	N/A
D7286	Incisional biopsy of oral tissue – soft	10%	10%	N/A
D7287	Exfoliative cytological sample collection	10%	10%	N/A
D7288	Brush biopsy	10%	10%	N/A
D7290	Surgical Reposition teeth	10%	10%	N/A
D7291	Transeptal fiberotomy	10%	10%	N/A
D7292	Placement of temporary anchorage device (screw retained plate) requiring flap; includes device removal	10%	10%	N/A

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D7293	Placement of temporary anchorage device requiring flap; includes device removal	10%	10%	N/A
D7310	Alveoloplasty in conjunction w/extractions – four or more teeth per quad	10%	10%	N/A
D7311	Alveoloplasty in conjunction w/extractions – one to three teeth per quad	10%	10%	N/A
D7320	Alveoloplasty not in conjunction w/extractions – four or more teeth per quad	10%	10%	N/A
D7321	Alveoloplasty not in conjunction w/extractions – one to three teeth per quad	10%	10%	N/A
D7340	Vestibuloplasty-ridge extension	10%	10%	N/A
D7350	Vestibuloplasty – ride extension (including soft tissue grafts, muscle reattachment, revision of soft tissue)	10%	10%	N/A
D7471	Removal of lateral (maxilla or mandible) exostosis	10%	10%	N/A
D7472	Removal of torus palatinus	10%	10%	N/A
D7473	Removal of torus mandibularis	10%	10%	N/A
D7485	Surgical reduction of osseous tuberosity	10%	10%	N/A
D7510	Incision and drainage abscess – intraoral soft tissue	10%	10%	N/A
D7610	Maxilla - open reduction (teeth immobilized, if present)	10%	10%	N/A
D7910	Suture of recent small wound up to 5 cm	10%	10%	N/A
D7953	Bone replacement graft for ridge preservation – per site	10%	10%	N/A
D7960	Frenulectomy – separate procedure	10%	10%	N/A
D7963	Frenuloplasty	10%	10%	N/A
D7970	Excision of hyperplastic tissue per arch	10%	10%	N/A
D7971	Excision of pericoronal gingiva	10%	10%	N/A
D7972	Surgical reduction of fibrous tuberosity	10%	10%	N/A
ADJUNCTIVE GENERAL SERVICES				
D9110	Palliative (emergency) treatment dental pain – minor procedure	NONE	NONE	N/A
D9210	Local anesthesia not in conjunction with operative or surgical procedures	NONE	NONE	N/A
D9215	Local anesthesia in conjunction with operative or surgical procedures	NONE	NONE	N/A
D9219	Eval for deep sedation or general anesthesia (frequency with exams)	NONE	NONE	N/A
D9222	Deep sedation/general anesthesia – first 15 minutes	10%	10%	N/A
D9223	Deep sedation/general anesthesia – each 15 minute increment	10%	10%	N/A
D9230	Inhalation of nitrous oxide/analgesia – DDS required	NONE	NONE	N/A
D9239	Intravenous moderate (conscious) sedation/anesthesia – first 15 minutes	10%	10%	N/A
D9243	Intravenous moderate (conscience) sedation/analgesia – each 15 minute increment	10%	10%	N/A
D9310	Consultation – per session	NONE	NONE	N/A
D9430	Office visit for observation (during regularly scheduled hours)	NONE	NONE	N/A

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D9630	Other drugs and/or medicaments	NONE	NONE	N/A
D9910	Application of desensitizing medicaments (dispensed in office)	NONE	NONE	N/A
D9951	Occlusal adjustment – limited	10%	10%	N/A