

Access

A unique, affordable alternative to conventional dental plans for groups of 10 to 49 enrolled employees

For effective dates of July 1, 2008 through June 1, 2009

Key Features

Choose any dentist

Access plans allow subscribers to select the dentist of their choice. Subscribers who choose Delta Dental network dentists may enjoy greater out-of-pocket savings resulting from Delta Dental's contractual fee agreements with network dentists.

No employer contribution required

Access can be offered without any employer contribution, but if the employer wishes to contribute, they may.

Vision discount program included

Access plans include a vision discount program. See page 4 for details.

Standard underwriting requirements

Access has the same underwriting requirements as Delta Dental of Wisconsin's popular MaxiMizer dental plans.

How Access Works

Access combines the best features of a conventional fee-for-service dental plan with the affordability that comes from a table of allowances benefit plan. Access Plus Plan provides a more generous allowance. Access Standard Plan pays a smaller allowance, but offers significantly lower rates. Both the Plus Plan and the Standard Plan cover diagnostic and preventive services at 100%, with no deductible, up to an annual maximum of \$150 per person.

Basic and major restorative services are covered through a schedule of benefits. After deductibles are met, the plan pays up to the table of allowances amount for specific services, based on standard dental procedure codes. In all, Access offers benefits on more than 170 procedures, including all of the most commonly performed restorative services. Samples of these allowances are listed below*.

Access does not cover all restorative services. Services not covered include dentures, implants and bridges. For a copy of the full Access table of allowances, contact the Delta Dental of Wisconsin sales department at 800-236-3713, or sales@deltadentalwi.com.

Code	Description	Access Standard Plan Pays	Access Plus Plan Pays
D2150	Amalgam -- two surfaces, primary or permanent	\$59.00	\$89.00
D2930	Prefabricated stainless steel crown -- primary tooth	\$100.00	\$150.00
D2940	Sedative filling	\$39.00	\$59.00
D2950	Core buildup, including any pins	\$101.00	\$152.00
D3330	Endodontic therapy -- molar (excluding final restoration)	\$441.00	\$662.00
D4341	Periodontal scaling and root planing	\$98.00	\$146.00
D4910	Periodontal maintenance	\$54.00	\$82.00
D7140	Extraction, erupted tooth or exposed root	\$57.00	\$84.00
D7230	Removal of impacted tooth -- partially bony	\$169.00	\$262.00

* Note: Allowances are subject to Delta Dental's standard processing policies, limitations and exclusions. Actual benefits may vary.

Plan Summary

Highlights:

- 10-49 enrolled employees
- Employer contribution required: 0%-100%
- Vision discount plan included

Plan Options	Standard or Plus
Deductible Options - Per Person, Per Year	\$25 or \$50
Diagnostic & Preventive Services — No Deductible Includes examinations, teeth cleanings, fluoride treatments once every 6 months. Bitewing x-rays once every 12 months, & full-mouth x-rays every 5 years. One-time application of sealants, through age 18. Space maintainers as needed.	100%, up to \$150 per person per calendar year
Individual Annual Maximum For Other Covered Services — Deductible Applies This annual maximum applies to procedure codes listed in the schedule of benefits. Covered services include fillings, crowns, root canal treatment, periodontal treatment, and oral surgery. See table on opposite page for examples of allowances for specific procedures.	\$1,000
Orthodontic Services Lifetime Maximum — Deductible Applies Orthodontic coverage is optional for dependents to age 19. Groups may add this coverage to their plan. The orthodontic benefit provides 50% coinsurance. There is a 12-month benefit waiting period.	\$1,000
Procedures Not Listed in Schedule of Benefits	Not covered
Dependent Age Limitation	Dependents covered to age 19; full-time students covered to age 25, except as noted for orthodontics
Vision Care Discount Program	Included -- See next page for details

Monthly Rates

	<u>With Ortho</u>		<u>Without Ortho</u>	
	<u>Single</u>	<u>Family</u>	<u>Single</u>	<u>Family</u>
Access Standard				
\$25 Deductible	\$24.79	\$73.73	\$24.79	\$67.09
\$50 Deductible	\$23.97	\$71.52	\$23.97	\$64.88
Access Plus				
\$25 Deductible	\$30.18	\$88.32	\$30.18	\$81.68
\$50 Deductible	\$28.74	\$84.42	\$28.74	\$77.78

Rate adjustment for selected business types

The types of businesses listed below are eligible for the Axxess program if they meet all other underwriting guidelines, but require a 19.7% adjustment on the rates printed above. This list is not all-inclusive. If you are uncertain about the industry type and whether or not a rate adjustment would apply, contact the sales department at our Stevens Point, Milwaukee or Madison offices. See the back page of this brochure for complete contact information.

Accounting, auditing & bookkeeping
 Advertising agencies
 Attorneys
 Automotive dealers, new and used
 Beauty/barber shops
 Boat dealers
 Bowling alleys
 Brokers (real estate, stock, food, etc.)
 Business & professional organizations
 Churches
 Dentist offices

Eating and drinking establishments
 Engineering & architectural services
 Farms
 Gas stations, convenience stores
 Home health care
 Hospitals, medical & dental labs
 Hotels, motels, campgrounds
 Insurance agents, brokers & service
 Labor organizations
 Local and suburban passenger transportation
 Management and public relations

Medical service and health insurance
 Mobile home dealers
 Motorcycle dealers
 Movie theaters
 Physician, other health care offices
 Political, civic & social organizations
 Recreation & utility trailer dealers
 Research & testing services
 Schools, including colleges & universities
 Subdividers and developers
 Travel agents/tour operators

Vision Discount

Access plans include a vision care discount program

Access dental plans include a vision discount program. The program utilizes a nationwide network administered by EyeMed Vision Care. The discount program provides:

- Overall savings up to 35% (see benefit description below)
- Access to thousands of private practice and retail providers nationwide, including LensCrafters, Target Optical, Sears Optical, ShopKo and most Pearle Vision locations
- Choice of any product, including designer brand name frames
- Savings on laser vision correction
- Replacement contact lenses by mail service

Service	Member Benefit
Exam with Dilation as Necessary	\$5 off comprehensive exam \$10 off contact lens exam
Complete Pair Glasses Purchased:	
<ul style="list-style-type: none"> • The following discounts and fees for frames, lenses, and lens options apply only if a complete pair is purchased in the same transaction. • Items purchased separately will be discounted 20% off of the retail price. 	
Frames: Any frame available at provider location	30% off retail price
Single Plastic Lenses Including Standard Scratch Coating:	Member Pays
Single Vision	\$75
Bifocal	\$95
Trifocal	\$125
Lens Options:	Member Pays
UV Coating	\$15
Tint (solid and gradient)	\$15
Standard Polycarbonate	\$40
Standard Anti-Reflective Coating	\$45
Standard Progressive (add-on to bifocal)	\$70
Conventional Contact Lenses: (Applied to materials only)	15% off retail price
Laser Vision Correction: LASIK or PRK	15% off retail price or 5% off promotional price
Frequency: Exams, Frames, Lenses and Contact Lenses	Unlimited

Additional Notes:

- After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com/deltadental.
- Member will receive 20% discount on items purchased at participating providers not included under the plan coverage. 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses.
- Retail prices may vary by location.

Plan Limitations/Exclusions:

- Orthoptic or vision training, subnormal vision aids, and associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Plano nonprescription lenses and nonprescription sunglasses (except for 20% discount).

Underwriting Guidelines

Group acceptance is not guaranteed. Approval of coverage is contingent upon underwriting acceptance.

Requirements & considerations for Access plans

- The group must have 10 to 49 enrolled employees.
- The plan must be sponsored by the employer. The employer will collect premiums via payroll deduction.
- The business is required to have been in operation for a minimum of 2 years.
- A clear employer-employee relationship must exist.
- Employment must be full time, year-round and not experience seasonal layoffs.
- The business has not been cancelled by another dental carrier within the past 36 months.
- Benefit accumulation period is calendar year.
- Subscribers may use the national Delta Dental Premier and Delta Dental PPO dentist networks.
- Only group-billing format is available; no individual billings can be accommodated. Individual COBRA billings are not available.
- Retirees are not eligible unless all active employees are eligible for the plan.
- In order to enroll dependents, the employee must be enrolled.
- All contracted services are available to the employee upon the date of eligibility.
- A new employee is eligible on the first of the month after completing a waiting period of at least 30 days.
- An employee who waived coverage or dropped coverage may enroll only during the open enrollment period.
- Access plans include coverage for teeth lost prior to the effective date, and pre-existing conditions.
- Access must be the only dental plan offered.
- Rates are guaranteed for one year from the effective date of coverage.

Exclusions

Access does not provide coverage for the following (see group contract or handbooks for definitions of terms used in this section):

1. Dental procedures provided or commenced prior to the effective date of the subscriber's or covered dependent's coverage under this contract.
2. Dental procedures to treat injuries or conditions compensable under worker's compensation or employer's liability laws.
3. Prescription drugs and premedications.
4. Preventive control programs.
5. Charges for completion of forms.
6. Charges for consultation.
7. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
8. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
9. Services that are determined to be partially or wholly cosmetic in nature.
10. Cast restorations placed on covered dependents under age 12.
11. Prosthetics placed on covered dependents under age 16.
12. Appliances, restorations, or procedures for: (a) increasing vertical dimension; (b) restoring occlusion; (c) correcting harmful habits; (d) replacing tooth structure lost by attrition; (e) correcting congenital or developmental malformations except in newly born children; (f) temporary dental procedures; (g) implantology techniques; (h) splints, unless necessary as a result of accidental injury.
13. Dental procedures provided by other than a dentist or licensed hygienist employed by a dentist.
14. Dental procedures to treat injuries or diseases caused by riots or any form of civil disobedience.
15. Dental procedures to treat injuries sustained while committing a criminal act.
16. Dental procedures to treat injuries intentionally inflicted.
17. Replacement of lost or stolen dentures or charges for duplicate dentures.
18. Dental procedures in cases for which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
19. Local anesthetic is covered as a part of a dental procedure. General anesthetic or intravenous sedation is a benefit only when billed with covered oral surgery (cutting procedures).
20. Procedures not specifically covered under this contract.
21. If orthodontic procedures are included as benefits under your group's contract, the repair and replacement of orthodontic appliances is not covered.

Limitations

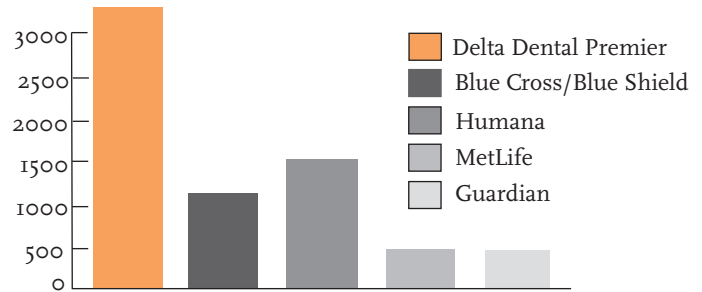
Coverage for some services under the Access plan is subject to frequency and age limitations. These limitations and restrictions are described in the handbook and group contract. Copies of these materials are available by calling Delta Dental of Wisconsin at 800-236-3713.

Delta Dental Dentist Networks —Savings and More!

Delta Dental Premier

More than 80% of Wisconsin dentists and 75% of dentists nationwide are members of the Delta Dental Premier network. Delta Dental Premier is a fee-for-service network that offers distinct advantages over traditional indemnity plans with features like treatment guarantees and no balance-billing.

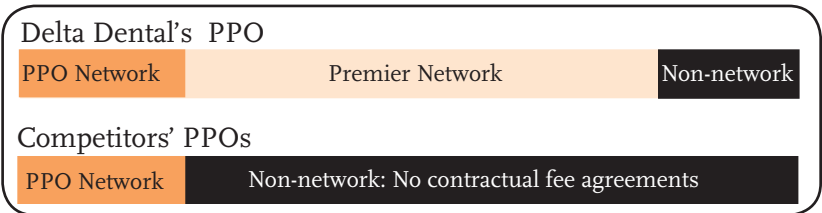
Wisconsin's Largest Dental Networks (Access Points)



Data comes from published sources produced by Blue Cross/Blue Shield, Guardian, Humana and MetLife.

Delta Dental PPO

With other carriers, savings occur only if subscribers see a network dentist. If they go out-of-network, they face a penalty from balance-billing by the provider. Delta Dental's PPO network is backed by our Premier network, which includes 80% of Wisconsin dentists and 75% of dentists nationwide. That means savings on out-of-pocket costs, and choices that help deliver patient satisfaction.



Delta Dental of Wisconsin

Stevens Point Office

P.O. Box 828 • Stevens Point, WI 54481
800-236-3713 • Fax 715-343-7623

Milwaukee Office

1233 North Mayfair Road, Suite 204 • Milwaukee, WI 53226
888-456-2711 (toll-free) • Fax 414-607-6088

Madison Office

725 Heartland Trail, Suite 205 • Madison, WI 53717
877-577-7449 (toll-free) • Fax 608-831-9384

www.deltadentalwi.com

APPLICATION

Delta Dental of Wisconsin

Access

Employer (Group) Name _____

Address _____
Street P.O. Box City State ZIP

Phone (____) _____ - _____ Fax (____) _____ - _____ Years in business _____

Nature of business _____ SIC code _____

Previous dental carrier _____ How long? _____

Have you been cancelled by another dental benefits carrier in the past 36 months? Yes No

Benefit contact name _____ Title _____ E-mail _____

Billing contact name _____ Title _____ E-mail _____

Current health carrier _____

Payment method: ACH Check (If ACH, complete information on the reverse side of this form)

Billing delivery method: E-mail Paper Fax If e-mail, specify e-mail address: _____

Plan Chosen: Access Standard Access Plus

Deductible: \$25 \$50

Orthodontic Coverage: Yes No

Employer contribution: _____% _____%
Single Family

Total number of eligible employees: _____ Total number employees enrolling: _____
(Include completed waivers for those not enrolling)

Requested effective date: _____ Waiting period for new employees: _____
(Must be at least the first of the month following 30 days of employment, or match medical)

Rates: _____ (Be sure to include rate adjustment for selected business types, if appropriate -- see page 3)
Single Family

Check this box if the group does **not** wish to include the vision discount plan. (Note: Opting out of the vision plan will **not** affect rates.)

In making this application to Delta Dental of Wisconsin (DDW) for group dental coverage under this program, the Group agrees and understands this application will become part of the Contract executed by an authorized officer of DDW. It is agreed that the coverage requested is subject to the approval of DDW and that no agent or representative has authority to make or modify this application for coverage. The Group hereby certifies that all of the above information is true and correct. The Group understands that coverage will not be effective until questions regarding eligibility for coverage have been satisfactorily resolved. The Group agrees to be bound by the terms of the Contract issued by DDW to the extent it does not conflict with this application. Misrepresentation of submitted data will cause this application and subsequent Contract to be null and void.

The Group also agrees to be bound by the terms of the Contract issued by DDW for the EyeMed Vision Care Discount Program to the extent it does not conflict with this application.

Signed: _____ Name: _____

Title: _____ Date: _____

Agent Statement: As the acting representative for the group represented in this application, I have to the best of my knowledge and ability complied with the underwriting guidelines listed by Delta Dental of Wisconsin.

Agent's Name _____ Fed. ID No. _____ Agency _____

Address _____ Phone () _____ - _____

License No. _____ Soc. Security No. _____ E-mail _____

If commission is to be paid to someone other than above, please state: _____

Delta Dental of Wisconsin is unable to accept this document with any changes, cross-outs, white-outs, etc. unless the person signing the application or the agent of record initials those changes. Approval of coverage is contingent upon underwriting acceptance.

Automated Clearinghouse (ACH) Transfer of Funds

Complete this section only if group will be paying via ACH

Automated clearinghouse (ACH) transfer of funds is a safe, easy and effective way to ensure proper funding of your group's account. Your completion of the information below will allow us to set up your ACH transfer.

The ACH transfer for your group premium will occur monthly. An e-mail or fax will be sent to the contact person you designate around the 15th of each month, providing the total amount to be withdrawn from your bank on the first business day of the following month. You may be charged a small fee by your bank for the ACH transfer.

In addition to the monthly ACH notification, you will receive a monthly billing invoice that details premium adjustments and the current billed for that month. The invoice can be delivered online through our Employer Connection, or you can receive a paper copy by mail.

Automated Clearinghouse Authorization Agreement for Preauthorized Payments

I (we) hereby authorize Delta Dental of Wisconsin, Inc., hereinafter called Company, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) account and the financial institution indicated below, herein called Depository, to debit and/or credit the same such account.

Group Name

Federal Tax ID Number

Group Number

Contact Person (to receive the monthly notification)

Contact Person's Phone

Contact Person's E-Mail

Contact Person's Fax

Notification Preference:

E-mail

Fax

Depository Name

Depository Transit/ABA Number

Account Name

Account Number

Savings or Checking?

Depository Contact Person

Depository Contact Person's Phone

This authority is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Depository a reasonable opportunity to act on it.

Name

Name

Signature

Date

Signature

Date

To enroll a group

Provide the following to Delta Dental prior to the first of the month the coverage is to be effective:

- An application for group dental coverage completed and signed by the employer.
- Completed enrollment/waiver cards for all full-time employees.
- A check from the group for the first month's premium, or completed ACH form.