DELTA DENTAL PPO
SUMMARY OF BENEFITS
FOR COVERED EMPLOYEES OF:

WELS VEBS Group Health Care

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

GROUP NUMBER: **50716 - 00000**

EFFECTIVE DATE OF PROGRAM: **January 1, 2025**

OPEN ENROLLMENT

Changes in enrollment status will be considered during an Open Enrollment Period determined by the Group, with changes becoming effective on the renewal date.

WAITING PERIOD

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

Wait until the next Open Enrollment Period.

TERMS OF ELIGIBILITY

Eligibility begins:
For eligible new employees, eligibility begins the date of employment.

For eligible new employees, the waiting period is 0 days.

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

Part-time employees are covered; minimum hours worked must average at least 20 per week.

Retired workers, totally disabled workers and surviving spouses (and their covered dependents) may be eligible to continue dental plan coverage on terms that are more favorable than COBRA continuation coverage, subject to the terms and provisions of the WELS VEBA Group Health Care Plan.

DEDUCTIBLE LIMITATIONS

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

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

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

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

MAXIMUM BENEFIT

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

The maximum total Benefit per Subscriber and per Covered Dependent, per Benefit Accumulation Period for Dental Procedures provided by Delta Dental PPO Providers is $1,000, or $1,000 for Dental Procedures provided by Delta Dental Premier Providers, or $1,000 for Dental Procedures provided by Noncontracted Providers. In no case will the maximum total Benefit exceed $1,000 regardless of the network chosen.

Benefit payments provided for evaluations, x-rays, prophylaxis, fluoride, space maintainers and sealants do not apply to the Maximum Benefit.

ORTHODONTIC MAXIMUM BENEFIT

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

The maximum lifetime orthodontic Benefit is $1,500 for each Covered Dependent child to age 19.

SCHEDULE OF BENEFITS, LIMITATIONS AND COVERAGE PERCENTAGE:

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

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

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

The Benefit Accumulation Period begins on January 1, 2025, ends on December 31, 2025 and thereafter shall be the 12 month period beginning on January 1st.

PPO = Delta Dental PPO Provider Premier = Delta Dental Premier Provider NC = Noncontracted Provider

Does Deductible Apply? Yes/No			**Coverage Percentage**			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
N	N	N	100	100	100	Evaluations two times per Benefit Accumulation Period.
N	N	N	100	100	100	Full mouth series x-rays at thirty six month intervals; either individual images, or panoramic image, including bitewings.
N	N	N	100	100	100	Bitewing x-rays two times per Benefit Accumulation Period (limited to a set of four images).
N Y	N Y	N Y	100 80	100 80	100 80	Prophylaxis (teeth cleaning) or periodontal maintenance procedure two times per Benefit Accumulation Period. Prophylaxis. Periodontal maintenance procedure.
N	N	N	100	100	100	Topical fluoride applications two times per Benefit Accumulation Period for Covered Dependent children up to age 19.
N	N	N	100	100	100	Space maintainers for retaining space when a posterior primary tooth is prematurely lost.
Y	Y	Y	80	80	80	Emergency treatment to relieve pain.
N	N	N	100	100	100	Topical application of sealants for Covered Dependents up to age 19. Application is limited to the occlusal surface of bicuspids and molars which are free of decay and restorations. Benefits for sealants are limited to one application per tooth per lifetime.
Y	Y	Y	80	80	80	Amalgam (silver) restorations.
Y	Y	Y	80	80	80	Composite (tooth colored) restorations for anterior teeth.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
Y	Y	Y	80	80	80	Prefabricated crowns – one per tooth at three year intervals.
Y	Y	Y	80	80	80	Endodontics including root canal treatment.
Y	Y	Y	80	80	80	Surgical endodontic treatment.
Y	Y	Y	80	80	80	Non-surgical periodontics, including procedures necessary for the treatment of diseases of the gums and bone supporting the teeth. Benefit is limited to once per quadrant at 24 month intervals.
Y	Y	Y	80	80	80	Surgical periodontic treatment; benefit is limited to once per quadrant at 36 month intervals.
Y	Y	Y	80	80	80	Non-surgical extractions.
Y	Y	Y	80	80	80	Oral surgery (cutting procedures) and surgical extractions including pre-operative and post-operative care.
Y	Y	Y	50	50	50	Crowns, inlays, or onlays are provided when teeth are broken down by dental decay or accidental injury and may no longer be restored adequately with a filling material. Coverage for the purpose of replacing a defective existing crown, inlay or onlay will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns are Benefits on the six front teeth, bicuspids, and upper first molars.

Does Deductible Apply? Yes/No			Coverage Percentage			
PPO	**Premier**	**NC**	**PPO**	**Premier**	**NC**	**Benefit**
Y	Y	Y	50	50	50	Prosthetics, including fixed bridgework, implants, partial dentures, and complete dentures to replace missing permanent teeth. Coverage for the purpose of replacing a defective existing prosthetic will be provided only after a five year period from the date on which the defective item was last supplied, whether or not Delta Dental paid for the original Dental Procedure as a Benefit under this Contract. Porcelain veneers on crowns or pontics are Benefits on the six front teeth, bicuspids, and upper first molars. Fixed bridges, implants, partial/complete dentures are provided where chewing function is impaired due to missing teeth. A fixed bridge or implant and implant related procedures may be a Benefit if no more than two teeth are missing in the dental arch in which the bridge or implant is proposed. Delta Dental will provide for replacement of missing teeth with the least elaborate procedure when three or more teeth are missing in the dental arch. Coverage for initial replacement of teeth is not limited to those lost while a Subscriber or Covered Dependent.
Y	Y	Y	50	50	50	Repairs and adjustments to prosthetic appliances. Denture reline or rebase is a Benefit at three year intervals.

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

OPTIONAL PROCEDURES

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

SPECIAL CONDITIONS

Changes in Coverage due to a qualifying event will be effective as determined by the Group.

Handbook is amended as follows:

Eligibility Section, Covered Dependents, 3. Your children's children until Your child reaches age 26.

AMENDMENT
TO
SUMMARY OF BENEFITS
FOR

WELS VEBS Group Health Care
50716 00000

This Amendment modifies the group dental Benefits afforded by the Policy with Delta Dental of Wisconsin, Inc., and must be read in conjunction with the Handbook and Summary of Benefits. All terms and conditions of the Policy remain in effect, except as modified by this Amendment. Please read this Amendment carefully.

Please be advised that on January 1, 2025, the following Evidence-Based Integrated Care Plan ("EBICP") Benefits are provided under your Policy. To participate in EBICP, eligible dental Policy enrollees or their Providers are required to set the appropriate health condition indicator online at deltadentalwi.com or a Delta Dental of Wisconsin representative will assist in setting the EBICP indicator by telephone. The EBICP Periodontal Disease health condition indicator will be automatically updated when non-surgical or surgical periodontal procedures are processed by Delta Dental of Wisconsin. This Amendment supersedes any previous amendment provided to you regarding EBICP.

The EBICP Benefits are as follows:

Periodontal Disease

1. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of surgical or non-surgical treatment of **Periodontal Disease**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

Diabetes

1. With an indicator of a **Diabetes** diagnosis, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

Pregnancy

1. With an indicator of **Pregnancy**, a participant is eligible for one additional dental visit for adult prophylaxis or periodontal maintenance during the pregnancy.

High Risk Cardiac Conditions

1. With an indicator for **High Risk Cardiac Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis. High risk cardiac condition indicators are:

    - History of infective endocarditis
    - Certain congenital heart defects (such as having one ventricle instead of the normal two)
    - Individuals with artificial heart valves
    - Heart valve defects caused by acquired conditions like rheumatic heart disease
    - Hyper tropic cardiomyopathy which causes abnormal thickening of the heart muscle
    - Individuals with pulmonary shunts or conduits
    - Mitral valve prolapse with regurgitation (blood leakage)

Suppressed Immune System Conditions

1. With an indicator for **Suppressed Immune System Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of **Suppressed Immune System Conditions**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

Kidney Failure or Dialysis Conditions

1. With an indicator for **Kidney Failure or Dialysis Conditions**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

Cancer Related Chemotherapy and/or Radiation

1. With an indicator for **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for up to two additional dental visits in a Benefit year for periodontal maintenance or adult prophylaxis.

2. With an indicator of **Cancer Related Chemotherapy and/or Radiation**, a participant is eligible for topical fluoride application beyond the age limitation of the Master Group Contract.

THIS AMENDMENT IS PART OF THE SUMMARY OF BENEFITS AND HANDBOOK REFERENCED HEREIN AND SHOULD BE KEPT WITH THOSE DOCUMENTS.

EBICPIIAmend 04.2016

AMENDMENT
TO
SUMMARY OF BENEFITS

This Amendment modifies the group dental Benefits listed in the Summary of Benefits and afforded by the Contract with Delta Dental of Wisconsin, Inc., and must be read in conjunction with the Handbook and Summary of Benefits. The Summary of Benefits remains unchanged except as modified by this Amendment. Please read this Amendment carefully.

Please be advised that on July 1, 2025, the following Special Health Care Needs (as defined below) Benefits are provided under your Contract. If a Subscriber or Covered Dependent satisfies the qualifications outlined in the **Special Health Care Needs Benefit Qualifications** section, the Benefits outlined in the **Special Health Care Needs Benefits** section are available to the applicable individual.

Special Health Care Needs Benefit Qualifications

For the Subscriber or Covered Dependent to participate in the Special Health Care Needs Benefits, all of the following must be true for that Subscriber or Covered Dependent:

1. The Subscriber or Covered Dependent has Special Health Care Needs;

2. The Subscriber's or Covered Dependent's Special Health Care Needs significantly impair the individual's ability to obtain routine covered dental services; and

3. The Subscriber's or Covered Dependent's Provider performs an initial assessment of the individual, concludes the individual satisfies the qualifications for Special Health Care Needs, and submits any requested documentation to Delta Dental. When the Provider makes the initial assessment, the Provider will assess their need to change or add new equipment, increase procedure time, and/or change or require additional therapeutic regimes and/or techniques to provide treatment. The Provider may ask for documentation evidencing the Subscriber or Covered Dependent's Special Health Care Needs.

"Special Health Care Needs" is any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition requiring medical management, health care intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental causes and may impose limitations in performing daily self-maintenance activities or substantial limitations in major life activities.

Special Health Care Needs may include any of the following:

- Intellectual and neurodevelopmental disabilities
- Environmental or congenital injuries leading to disability
- Chromosomal abnormalities
- Syndromes or sequences with craniofacial or airway abnormalities
- Other sequences that require special dental care needs
- Any other syndrome, sequence, or abnormality which is not otherwise specified but has a significant deleterious effect in activities of daily living and/or requires significant modification at home and/or in care settings

Special Health Care Needs does not include a standalone diagnosis of anxiety, depression, or fear of dentists or dental treatment (odontophobia) which is not part of a covered condition.

Special Health Care Needs Benefits

If a Subscriber or Covered Dependent satisfies the qualifications for the Special Health Care Needs Benefits as outlined in the **Special Health Care Needs Qualifications** section above, the **Schedule of Benefits, Limitations and Coverage Percentage** table in the Summary of Benefits will be amended as follows for that individual:

1. The individual is eligible for an unlimited number of evaluations beyond any frequency limitations for such benefit in the Contract.

2. The individual is eligible for up to two additional dental visits per Benefit Accumulation Period for periodontal maintenance or prophylaxis.

3. Dental case management is added as a Benefit for the individual. The Deductible and Maximum Benefit (annual plan maximum), if any, apply.

4. Behavior management is added as a Benefit for the individual. The Deductible and Maximum Benefit (annual plan maximum), if any, apply.

5. Up to four (4) units of general anesthesia is added as a Benefit for the individual. The Deductible and Maximum Benefit (annual plan maximum), if any, apply.

6. Application of desensitizing medication is added as a Benefit for the individual. The Deductible and Maximum Benefit (annual plan maximum), if any, apply.

THIS AMENDMENT IS PART OF THE SUMMARY OF BENEFITS AND HANDBOOK REFERENCED HEREIN AND SHOULD BE KEPT WITH THOSE DOCUMENTS.