MASTER GROUP CONTRACT

Issued by

DELTA DENTAL OF WISCONSIN, INC.

and/or

WYSSTA INSURANCE COMPANY, INC.

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

Dental Benefits under the Contract are provided by Delta Dental of Wisconsin, Inc. ("Delta Dental") and vision Benefits under the Contract are provided by Wyssta Insurance Company, Inc., ("Wyssta").

ARTICLE I
DEFINITIONS

1.1 "Benefit" or "Benefits" means those dental Benefits and/or vision Benefits that are covered by the Company under the terms of this Contract as specified in the Schedule of Benefits.

1.2 "Certificate" means the Benefit Handbook(s) and Certificate(s) issued to a Subscriber insured through the Group. The Certificate outlines the Benefits provided by the Master Group Contract.

1.3 "Contract Term" means the period commencing and terminating on the dates shown in the Declarations, and each annual period thereafter during which the Contract remains in effect.

1.4 "Coinsurance" means the percentage of the Maximum Plan Allowance paid by the Subscriber or Covered Dependent for a specific Benefit each time such Benefit is provided under this Contract, subject to the Coverage Percentage.

1.5 "Company" means:

(a) with respect to dental Benefits, Delta Dental of Wisconsin, Inc., and

(b) with respect to vision Benefits, Wyssta Insurance Company, Inc.

1.6 "Contract" means the Master Group Contract, Declarations, Insuring Agreement Endorsement, and any other endorsements attached to the Master Group Contract, together.

1.7 "Coverage Percentage" means the percentage of the Maximum Plan Allowance paid by the Company for a specific Benefit, as specified in the Declarations.

1.8 "Covered Dependent" means a Dependent who:

(a) is listed in the documents necessary for coverage under the Contract,

(b) has been accepted by the Company as a Covered Dependent, and

(c) for whom the appropriate premium has been paid.

1.9 "Declarations" means the document(s) labeled "Declarations" and which lists the Group name, the Contract term, coverage limits, coverage option(s), and other information particular to the Group.

1.10 "Deductible" means the specified dollar amount that a Subscriber or Covered Dependent is required to pay each Contract Term before the Company will pay for Benefits as specified in the Schedule of Benefits. The Deductible is applied to the fee for Benefits that the Company contracts to pay or to the Maximum Plan Allowance for Benefits, whichever is applicable.

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

1.12 "Dependent" means a person who has satisfied the criteria for eligibility listed in Paragraph 3.1(b).

1.13 "Eligible Employee" means an employee or member of the Group who has satisfied the criteria for eligibility listed in Paragraph 3.1(a).

1.14 "Emergency" and "Urgent" mean a serious condition that manifests itself by acute symptoms of sufficient severity, including severe pain, lead a prudent layperson who possesses an average knowledge of health and medicine to reasonably conclude that a lack of immediate professional attention will likely result in any of the following:

(a) Serious jeopardy to the person's health or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child.

(b) Serious impairment to the person's bodily functions.

(c) Serious dysfunction of one or more of the person's body organs or parts.

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

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

1.17 "Master Group Contract/Contract" means this Contract. For dental Benefits, it is the group dental insurance policy issued by the Company to the Group in which Delta Dental agrees to provide dental Benefits to Subscribers and Covered Dependents. For vision

Benefits, it is the group vision insurance policy issued by the Wyssta to the Group in which Wyssta agrees to provide vision Benefits to Subscribers and Covered Dependents. The Contract includes the group application, the Declarations (including the Schedule of Benefits), the Master Group Contract, the Insuring Agreement Endorsements, and any attached addenda, appendixes, endorsements, schedules or riders.

1.18 "Maximum Plan Allowance" means the total dollar amount allowed under the Contract for a specific Benefit. The Maximum Plan Allowance will be reduced by any Deductible and Coinsurance the Subscriber or Covered Dependent is required to pay.

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

1.20 "Premium" means the total monthly fee due based on the number of Subscribers multiplied by the applicable Rate.

1.21 "Rate" means the monthly fee required for each Subscriber, including Covered Dependents if any, in accordance with the terms of the Contract.

1.22 "Schedule of Benefits" is a listing of the specific Benefits and Benefit limitations for dental Benefits and/or vision Benefits provided under the terms of this Contract. The Schedule of Benefits is attached to the Declarations.

1.23 "Subscriber" means an Eligible Employee or member of the Group who:

(a) has completed and signed the documents necessary for coverage under the Contract,

(b) has been accepted by the Company as a Subscriber, and

(c) for whom the appropriate Premium has been paid.

1.24 "Urgent Care Grievance" means any dissatisfaction with the administration or claims practices of or provision of services by the Company that requires immediate dental attention. Such grievance must be delivered in writing to the Company

See Grievance Procedures, Article VII.

1.25 "Wyssta" means Wyssta Insurance Company, Inc.

ARTICLE II
RESPONSIBILITIES OF THE PARTIES

2.1 Responsibilities of Group.

(a) Initial Enrollment. Subject to any Open Enrollment Period and the effective date of this Contract, the Group shall offer to all of its Eligible Employees the opportunity

to subscribe for themselves and their Dependents to the Benefit option(s) chosen by the Group in lieu of any other benefit plan(s) offered by the Group. New employees who become Eligible Employees will be given the opportunity to enroll themselves and any Dependents.

(b) Open Enrollment. During the Open Enrollment Period, if applicable, and only during such period unless otherwise specified in this Contract, the Group shall allow Eligible Employees to elect coverage or change coverage. Each Eligible Employee must complete the appropriate enrollment form and return it to the Group during the Open Enrollment Period. The Group will report these changes to the Company. If the Company approves coverage, the effective date of coverage will be the Contract renewal date. It is the Group's responsibility to verify that the employee is eligible. Upon request the Group agrees to provide to the Company proof of employee eligibility. The Company may periodically audit Group's records regarding eligibility in accordance with Paragraph 4.1(d).

(c) The Group agrees to collect and remit to the Company the monthly Premium for all Subscribers and Covered Dependents. The Premium will be due and payable by the first day of the month for which coverage is provided.

(d) The Group agrees to provide to the Company, in a form approved by the Company, the enrollment information requested by the Company for each person who becomes a Subscriber or Covered Dependent within 31 days of the date the Subscriber or Covered Dependent enrolls. In addition, the Group agrees to provide the Company with any subsequent change in a Subscriber's or Covered Dependent's enrollment. This includes, but is not limited to:

(i) eligibility for Medicare;

(ii) loss of eligibility for coverage under this Contract due to termination of employment, divorce or death of the Subscriber;

(iii) the addition of newly acquired Dependents, or

(iv) the deletion of Covered Dependents.

(e) The Group agrees to submit subscriber enrollment data to the Company on no less than a monthly basis, reporting all changes in Subscribers and Covered Dependents entitled to receive Benefits. The effective, termination, or change date for a Subscriber must not be more than 90 days prior to the date on which the change was requested or the last renewal date of the Contract, or the last day of the month in which a Benefit payment was made on behalf of the Subscriber or Covered Dependent, whichever is later. The Group will be liable for claims incurred after the termination or change date and prior to the date of receipt and acceptance of the notice by the Company.

(f) The Group is responsible for:

(i) timely delivery of the Company's standard identification card(s) (if applicable), and Certificate(s) to each Subscriber;

(ii) advising the Subscriber of Benefits changes in a timely manner; and

(iii) notifying the Subscriber of cancellation of this Contract.

(g) The Group agrees to notify the Company within ten days of a change in its legal status, expansion of business, dissolution of business, merger, acquisition, or any other significant business operational change.

2.2 Responsibilities of Delta Dental and/or Wyssta

(a) Benefits Generally. In consideration of the Premium paid by the Group, the Company agrees to provide to Subscribers and Covered Dependents the Benefits described in the Insuring Agreement Endorsement(s) attached hereto for the Benefit option(s) chosen by the Group.

(b) The Rates for coverage are stated in the Declarations of this Contract. Each month's Premium will be calculated based upon the number of current Subscribers, and according to their enrollment status. The Company will notify the Group of any future change in the Rate at least 30 days (60 days if the increase is more than 25%) prior to the date of Contract renewal.

(c) Upon initial enrollment, the Company will provide the Group with the Company's standard identification card(s) (if requested), Certificates, Declarations and Schedules of Benefits in sufficient quantity for the Group to distribute to each Subscriber. The Company may provide, at the Group's request, camera-ready language which the Group may print and distribute to Subscribers. Group agrees that it will not modify the camera-ready language provided by the Company.

(d) The Company has the sole authority to make Benefit determinations.

(e) The Company reserves the right to make payment for Benefits directly to Subscribers. This provision will control even if the Subscriber has assigned the Subscriber's rights to the payment of Benefits.

ARTICLE III
ELIGIBILITY; ENROLLMENT; EFFECTIVE DATE OF COVERAGE; TERMINATION OF ENROLLMENT

3.1 Eligibility

(a) Employees:

(i) Any employee who averages the number of hours of employment stated in the Declarations and who has completed the waiting period as established under Item 3 of the Declarations.

(ii) An employee no longer meeting such conditions who has elected to continue coverage under Paragraph 3.6.

(b) Dependents:

(i) The Eligible Employee's lawful spouse.

(ii) The Eligible Employee's unmarried children (including any unmarried children's children until the Employee's child is 18) including step and adopted children and children placed for adoption with the Eligible Employee, who satisfy all of the following:

(a) The child is less than 27 years of age, regardless of student status; and

(b) The child is not eligible for coverage under a group dental benefit plan that is offered by the child's employer and for which the amount of the child's premium is not greater than the Premium for coverage as a Dependent under this policy.

(iii) Notwithstanding (i) and (ii) above, the Eligible Employee's unmarried adult Dependent children, including step and adopted children and children placed for adoption with the Eligible Employee may be covered under this Contract if the adult child satisfies all of the following:

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

(b) The child is not eligible for coverage under a group dental plan that is offered by the child's employer and for which the amount of the child's premium is not greater than the Premium for coverage as a Dependent under this policy; and

(c) The child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher learning; and

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

(iv) An unmarried Dependent child over age 27 who is financially dependent on the Eligible Employee because of physical or mental incapacity that commenced while covered under this policy and prior to the Dependent child reaching age 27, provided a physician's certificate of disability is submitted within six months following the Dependent child's 27th birthday. The Company reserves the right to request proof of continued disability from time to time, but not more often than annually after the two-year period immediately following the Dependent child's attainment of the limiting age.

(c) If an Eligible Employee or Covered Dependent is activated while in the Reserve or National Guard, coverage terminates at the time of departure for active duty. Covered Dependents of activated Reserve and National Guard personnel may elect continuation of coverage as described under Paragraph 3.6. Upon return to civilian status, the Eligible Employee or Covered Dependent will be reinstated on the date he/she returns to work.

3.2 Effective Date of Eligible Employee's Coverage

The effective date of coverage for a Subscriber is specified in the Declarations.

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

3.3 Effective Date of Eligible Dependent's Coverage

Except as otherwise stated in this Paragraph 3.3, if the Eligible Employee chooses family coverage, if available, the effective date of a Covered Dependent's coverage is the effective date of the Eligible Employee's coverage. Any change in coverage selection (single or family) because of marriage, divorce, or death causing a change in enrollment status will be effective as specified in the Declarations.

Coverage of a newborn child of a Subscriber is effective on the child's date of birth. The Subscriber must notify the Company within 60 days of the birth of a child. Additional Premium will be required if the Subscriber is not enrolled for family coverage. When additional Premium is required, Premium will be charged from the first day of the month following the date of birth. If the Premium payment is not made, coverage for the newborn child will cease on the 61st day after birth unless within one year after birth the Subscriber pays the Company all past due Premium and 5½% interest per year on any past due Premium.

If the Subscriber notifies the Company and pays the additional Premium, if any is required, within 60 days of an adoption or placement for adoption, the adopted child's coverage will be effective on the date of adoption, the date of a final order granting adoption, or the date the child is placed for adoption, whichever comes first.

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

3.4 Enrollment

Eligible Employees must elect coverage during the initial eligibility period specified in the application for enrollment or during an Open Enrollment Period, if applicable, in order to receive Benefits. Persons not eligible during an Open Enrollment Period may be enrolled immediately upon attaining eligibility.

The Group agrees to complete and furnish to the Company on or prior to the first day of every month eligibility data in a format approved by the Company showing all Subscriber change information. The Company will be obligated to provide Benefits only to Eligible Employees and Dependents who are enrolled and are reported on the list of Subscribers submitted by the Group and for whom the appropriate Premium has been paid under Article IV of this Contract for the period for which Benefits are provided.

The Open Enrollment Period is the period of time in which Eligible Employees and Subscribers may elect or change coverage, if such period is offered to the Group in the Declarations. Except as otherwise stated in this Contract, if an Eligible Employee declined coverage for himself/herself, or family coverage if family coverage is available under this Contract, then election of coverage or a change to family coverage may only occur during the Open Enrollment Period. Any changes made will be effective on the renewal date of the Contract.

3.5 Termination of Subscriber and Covered Dependent Coverage

(a) Subject to any rights to continue coverage provided under Paragraph 3.6, enrollment under this Contract of any Subscriber or Covered Dependent may be terminated, or renewal of enrollment refused by the Company, under the following circumstances:

(i) The Contract is cancelled or not renewed under Article VIII. If cancelled, coverage ends on the effective date of cancellation. If nonrenewed, coverage ends on the expiration date.

(ii) The date on which the Subscriber or Covered Dependent loses eligibility. Eligibility of employees shall terminate on the last day of the month on which full-time employment terminates. Dependents of an employee are eligible until the employee's eligibility terminates or until loss of Dependent status, whichever occurs first. Loss of Dependent status shall occur on the date on which the Dependent ceases to meet the requirements contained in Section 3.1 (b) herein.

(iii) Upon ten days' written notice if the Subscriber or Covered Dependent knowingly perpetrates or permits another person to make a material misrepresentation in obtaining Benefits under this Contract.

(iv) Termination of coverage of a Subscriber shall automatically terminate the coverage of any Dependent of that Subscriber on the same date that the Subscriber's coverage terminates.

(b) Upon termination of Subscriber or Covered Dependent coverage as indicated above, no further Benefits shall be provided under this Contract to a terminated Subscriber or Covered Dependent.

3.6 Continued Coverage

Under Title X of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), Subscribers and Covered Dependents in employer groups of more than 20 employees ("Qualified

Beneficiaries") are permitted to elect continuation of coverage under this Contract upon the occurrence of any of the following "Qualifying Events":

(a) Subscriber:

(i) Termination of employment, voluntary or involuntary, except for reasons of gross misconduct; or

(ii) Reduction in hours to fewer than the minimum required to be an Eligible Employee under this Contract.

(b) Covered Dependents:

(i) If the Covered Dependent is the Subscriber's spouse:

(A) Death of Subscriber; or

(B) Termination of Subscriber's employment, except for reasons of gross misconduct; or

(C) Reduction of Subscriber's hours to fewer than the minimum required for eligibility for coverage under this Contract; or

(D) Divorce or legal separation from Subscriber; or

(E) Subscriber's Medicare entitlement.

(ii) If the Covered Dependent is the Subscriber's child:

(A) Child ceases to be a Dependent; or

(B) Death of Subscriber; or

(C) Termination of Subscriber's employment, except for reasons of gross misconduct; or

(D) Reduction in Subscriber's hours to less than the minimum required to be eligible as a Subscriber under this Contract; or

(E) Subscriber becomes entitled to Medicare; or

(F) Parents become divorced or legally separated.

The Group must provide notice to the Subscriber and to Covered Dependents, as applicable, of the right to elect COBRA continuation coverage.

A Covered Dependent whose coverage is terminated due to divorce, legal separation or cessation of eligibility for Dependent coverage must provide the Group notice of such event within 60 days of its occurrence.

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

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

(a) Eighteen months after the Subscriber's employment termination or reduction in hours.

(b) Twenty-nine months after the Qualifying Event for

(i) a Qualified Beneficiary who is determined to be disabled under the Social Security Act at anytime during the first 60 days of COBRA coverage and who notifies the Group of such determination within the first 18 months of COBRA coverage; and for

(ii) any nondisabled Qualified Beneficiaries with respect to the same Qualifying Event.

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

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

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

(f) The date on which coverage begins under another group dental and/or vision plan, as applicable. However, a person who has elected COBRA continuation coverage and whose new plan contains a pre-existing limitation clause can maintain COBRA continuation coverage until all pre-existing limitations under the new plan are satisfied.

(g) The date the Qualified Beneficiary becomes entitled to Medicare benefits.

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

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

ARTICLE IV
PREMIUMS; DEDUCTIBLES; INSURANCE; COVERAGE REQUIREMENTS

4.1 Premiums

(a) Premiums payable by the Group under this Contract are based on the number of Subscribers and the applicable Rate under each Benefit option at the time of initial enrollment and are adjusted monthly to reflect the current number of Subscribers. If the number of Subscribers reported by the Group for any month during the term is less than the number of Subscribers reported for the first month of the Contract Term by greater than 10%, or drops below the required minimum enrollment identified in the Declarations, the Company may adjust the Rate or terminate this Contract as provided in Paragraph 8.1(b).

(b) The Group agrees to pay the Company the Premium in full by the first day of the month for which coverage is in effect. The Contract provides a 31-day grace period. If Premiums are not paid on or before the date they are due, they must be paid during the 31-day period following that date. The Contract will terminate at the end of the grace period if the Premiums have not been paid. The Group is responsible for payment of Premiums for coverage provided during the grace period.

(c) In the event the Company is notified of any change to, or termination of, coverage of a Subscriber with respect to which the Group failed to provide prompt notice, the Company will refund or adjust Premium retroactively for a three-month period preceding the date of such notice, provided the Company has paid no claims during that three-month period. No adjustment will be made if Delta Dental has paid claims after the change to or termination of coverage.

(d) The Group agrees to permit the Company, by its auditors or authorized representatives, on reasonable advance written notice, to inspect its records to verify the accuracy of lists of Eligible Employees and Dependents prepared by the Group and submitted to the Company.

4.2 Deductible

In addition to any other limitations on specific Benefits that are described in the Schedule of Benefits, Benefits also are subject to any Deductible described in the Declarations. Subscribers are required to satisfy any applicable Deductible before the Company is obligated to pay Benefits under the Contract.

4.3 Coinsurance

In addition to any other limitations on specific Benefits that are described in the Schedule of Benefits, Benefits will be subject to the Coinsurance indicated in the Schedule of Benefits. Subscribers and Covered Dependents are required to pay any such Coinsurance amounts directly to the provider.

ARTICLE V
GENERAL EXCLUSIONS

This Contract does NOT cover any of the following:

5.1 Any Services, supplies, treatment or any other dental or vision procedures provided or commenced prior to the effective date of the Subscriber's or Covered Dependent's coverage under the Contract.

5.2 Any Services, supplies, treatment or any other dental or vision procedures to treat injuries or conditions compensable under worker's compensation or employer's liability laws.

5.3 Charges for completion of forms.

5.4 Charges for vision consultation.

5.5 Any Services, supplies, treatment or any other dental or vision procedures excluded as provided in the Declarations.

5.6 Procedures not specifically covered under this Contract.

ARTICLE VI
COORDINATION OF BENEFITS AND PROCEDURES

6.1 Applicability

(a) This Coordination of Benefits (COB) provision applies to This Plan when a Subscriber or Covered Dependent has health care coverage under more than one Plan. "Plan" and "This Plan" as used in this Article VI are defined below.

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

(i) shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another Plan, but

(ii) may be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in Paragraph 6.4 below, Effect on the Benefits of This Plan.

6.2 Definitions

In addition to the definitions of this Contract, the following definitions apply to this Article:

(a) "Allowable Expense" means a necessary, reasonable, and customary item of expense that is covered at least in part by one or more of the Plans covering the person for whom the claim is made.

When a Plan provides benefits in the form of services, the reasonable cash value of each procedure provided shall be considered both an Allowable Expense and a dental Benefit paid.

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

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

(i) 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.

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

(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 dental Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When the Company is the Secondary Plan, the Company may reduce the Benefits under this Plan only when the sum of the following exceeds the total allowable expense in a Claim Determination Period.

(i) The benefits the Secondary Plan would pay for Allowable Expenses in the absence of COB; plus

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

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

to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Claim Determination Period.

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

(e) "This Plan" means this Contract.

6.3 Order of Benefit Determination Rules

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

(i) the other Plan has rules coordinating its benefits with those of This Plan; and

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

(b) Rules. This Plan determines its order of benefits using the first of the following rules, which applies.

(i) Nondependent/Dependent. The benefits of the Plan that covers the person as an employee, member or subscriber are determined before those of the Plan that covers the person as a dependent of an employee, member or subscriber.

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

(A) the benefits of the Plan of the parent whose birthday falls earlier in the calendar year are determined before those of the Plan of the parent whose birthday falls later in the calendar year; but

(B) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent.

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

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

(A) first, the Plan of the parent with custody of the child;

(B) then, the Plan of the spouse of the parent with custody of the child; and

(C) finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent and the entities obligated to pay or provide benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the dependent child shall be determined according to Paragraph 6.3(b)(ii).

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

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

(v) Continuation Coverage.

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

1. First, the benefits of a Plan covering the employee, member, or subscriber or dependent of an employee, member, or subscriber.

2. Second, the benefits under the continuation coverage.

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

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

If a covered person is entitled to coverage under a group health care plan which primarily covers services or expenses other than dental care, and if the covered person first became eligible under the Plans on the same date, this Plan shall be the secondary payor for those services covered by both Plans.

6.4 Effect on the Benefits of This Plan

(a) When This Paragraph Applies. This Paragraph 6.4 applies when, in accordance with Paragraph 6.3, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other plans. In that event, benefits of This Plan may be reduced under this paragraph so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than the total Allowable Expenses. Such other Plan or Plans are referred to as "the other Plans" in (b).

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

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

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

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

6.5 Right to Receive and Release Needed Information

The Company has the right to decide the facts it needs to apply these rules. The Company 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 applicable state and federal law. Each person claiming benefits under This Plan must give the Company any facts it needs to pay the claim.

6.6 Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, This Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. The Company 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.

6.7 Right of Recovery

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

(a) the person(s) it has paid or for whom it has paid;

(b) insurance companies; or

(c) other organizations.

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

ARTICLE VII
CLAIMS AND GRIEVANCE PROCEDURES

7.1 Prior Approval of Benefits

Your group dental and/or vision plan does not require prior approval before dental and/or vision services are provided. However a Subscriber or Covered Dependent, or the Subscriber's or Covered Dependent's Dentist, may request a predetermination of Benefits to obtain advance information on coverage under the Group's plan before services are rendered. Payment, however, is limited to the Benefits that are covered under the Group's plan and is subject to any applicable deductibles, copayments, coinsurance, waiting periods, and annual lifetime benefit maximums.

7.2 How to Contest a Claim Denial

(a) Urgent Care Situations:

(i) Method of Notification. Notice of an Urgent Care Grievance will be accepted by the Company if made by a Subscriber or Covered Dependent, or that person's representative, by telephone or in writing directed to:

If for dental Benefits:	If for vision Benefits:
Delta Dental of Wisconsin, Inc. 2801 Hoover Road, P.O. Box 828 Stevens Point, WI 54481-0828 800-236-3712	Wyssta Insurance Company, Inc. 2801 Hoover Road, P.O. Box 85 Stevens Point, WI 54481-0085 800-883-3920

(ii) Resolution Process. If the Urgent Care Grievance cannot be resolved through informal discussions, consultations or conferences during the first 48 hours after the Company's receipt of the Urgent Care Grievance, the Subscriber, Covered Dependent, or a designated representative may appear before the Company's Grievance Committee to present written or oral information with the right to ask questions before the Grievance Committee.

(iii) Time Limitation for Resolution. An Urgent Care Grievance will be resolved, whether informally or by the Grievance Committee, within 72 hours of its receipt by the Company.

(b) All Other Grievance Situations Not Including Urgent Care:

(i) Denial of a Claim for Benefits.

If a Subscriber or Covered Dependent makes a claim for Benefits under the Group's dental or vision plan and the claim is denied in whole or in part, the Subscriber or the Covered Dependent, or his/her service provider, will receive written notification within 30 days after the Company receives the claim, unless special circumstances require an extension of time for processing. The claims decision will be sent on a form entitled "Explanation of Benefits."

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

(ii) Appealing a Claim Denial.

If the Subscriber or Covered Dependent has questions about the denial of his/her claim for Benefits, he/she should contact Delta Dental at **800-236-3712** for questions on dental claims and Wyssta at **800-883-3920** for questions on vision claims. Because most questions about Benefits can be answered informally, the Company encourages Subscribers and Covered Dependents to first try resolving any problem by talking with the Company. However, Subscribers and Covered Dependents have the right to file an appeal requesting that the Company formally review the Benefits Determination.

To file a grievance or to appeal a Benefits determination, contact the Company's Benefit Services Department at **800-236-3712**, fax your request to 715-343-7615, or mail your request to:

For dental Benefits:

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

For vision Benefits:

Wyssta Insurance Company, Inc.
2801 Hoover Road, P.O. Box 85
Stevens Point, WI 54481-0085

The Subscriber or Covered Dependent should provide the reasons why he/she disagrees with the Company's Benefits determination and include any documentation he/she believes supports his/her claim. He/she should include the Subscriber's name, the Covered Dependent's name if applicable, and the Subscriber's Social Security number on all supporting documents.

(iii) Resolution Procedure.

The Company will acknowledge the Grievance or Benefits determination appeal within five days of its receipt by the Company. The Company will attempt to resolve the Grievance or Benefits determination appeal through informal discussions, consultations or conferences. In the event that the Grievance or appeal remains unresolved, the Subscriber or Covered Dependent, or his/her representative, has the right to appear before the Company's Grievance Committee to present written or oral information and to question the Grievance Committee. The Committee shall advise the Subscriber, Covered Dependent, or his/her representative, of the time and place of the meeting at least seven calendar days before the meeting.

If the Subscriber or Covered Dependent does not exhaust the appeal procedures described above, and if he/she files a lawsuit against the Group's plan and/or Delta Dental or Wyssta, as applicable, seeking payment of Benefits, the court may not permit the Subscriber or Covered Dependent to go forward with his/her lawsuit because he/she failed to utilize the Company's grievance/claims appeal procedures. No legal action can be brought against the Company later than three years after the date of the Grievance Committee's final decision on the review of the Benefits determination.

(iv) Time Limitations for Resolution.

The Company will attempt to resolve all Grievances and Benefit determination appeals within 30 calendar days after receipt by the Company. The Company will inform the Subscriber or Covered Dependent of its decision in writing. If the appeal is denied in whole or in part, the notice will include the following information:

(A) The specific reason(s) for the denial of the appeal;

(B) The reference to the specific Contract provision(s) on which the denial is based;

(C) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim;

(D) A statement describing any voluntary appeal procedures offered by the Company and the claimant's right to obtain information about such procedures; and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

(E) If an internal processing policy or other similar criterion was relied upon in the denial of the appeal, the notice of such denial also will include either the specific processing policy or a statement that such processing policy was relied upon in denying the appeal and that a copy of that processing policy will be provided free of charge to the claimant upon request;

(F) If the denial of the appeal was based on a dental or vision necessity, experimental treatment or similar exclusion or limit, the notice of such denial also will include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Contract to the claimant's circumstances, or a statement that such explanation will be provided free of charge upon request; and

(G) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the Grievance or Benefit determination appeal cannot be resolved within 30 days from receipt by the Company, the Company will notify the Subscriber, Covered Dependent, or his/her representative, in writing that it intends to extend the period of time for resolution an additional 30 days. The notification will state when resolution may be expected and the reasons for the additional time needed.

All Grievances and Benefit Determination appeals will be resolved within 60 days from date of receipt by the Company.

The Company's Grievance Committee shall consist of four persons: a consultant chosen by the Company, a representative of Company management, the Company's claim administrator, and a Subscriber in a Company plan who is not a Company employee.

The Subscriber or Covered Dependent may resolve any grievance through the Company's Grievance procedure outlined above. The Subscriber or Covered Dependent may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency that enforces Wisconsin's insurance laws, and file a complaint. The Subscriber or Covered Dependent can contact the OFFICE OF THE COMMISSIONER OF INSURANCE BY WRITING TO:

OFFICE OF THE COMMISSIONER OF INSURANCE
Complaints Department
P.O. Box 7873
Madison, WI 53707-7573

or the Subscriber or Covered Dependent can call 800-236-85l7 outside of Madison, or 266-0103 in Madison, and request a complaint form.

ARTICLE VIII
TERM; TERMINATION; NONRENEWAL

This Contract shall remain in force for the term stated in the Declarations as long as the Premium is paid on a timely basis unless terminated sooner as specified in Paragraph 8.2. This Contract will renew continuously and automatically on the anniversary date of the effective date of This Contract unless the Group requests nonrenewal.

8.1 Cancellation

(a) The Group may cancel this Contract by giving the Company 30 days' notice in writing.

(b) The Company may cancel the Contract by giving Group ten days' notice in writing upon the occurrence of any one or more of the following events:

(i) The Group fails to make a required Premium payment within the 31-day grace period.

(ii) For substantial breach of contract if the Group fails to furnish the Company with accurate enrollment data pursuant to Paragraph 3.4 of this Contract.

(iii) For substantial breach of contract if the Group permits enrollment which is contrary to specifications in the Declarations, or the initial group application.

(iv) For substantial change in the risk assumed if the Group changes the amount of Subscriber contribution or the conditions under which Benefits are offered, including but not limited to flexible benefit plans, flexible spending accounts, cafeteria plans, and the introduction of other plans from which the Subscribers may choose.

(v) For misrepresentation if the information relied upon in the application was inaccurately represented and would have caused the Group to be unacceptable to the Company at the time the Contract was issued.

(c) Delta Dental may cancel the Contract upon giving the Group 30 days' written notice in the event of any of the following:

(i) For substantial breach of contract if the Group refuses to allow the Company (by its auditors or other authorized representatives) to inspect its records in order to verify the accuracy of the Subscriber and Covered Dependent list.

(ii) The Group is no longer engaged in the type of business the Company agreed to insure.

8.2 Nonrenewal

Should the Company exercise its right to nonrenew this Contract, it will give the Group notice of such nonrenewal at least 60 days prior to the expiration date. Nonrenewal may occur if the Group allows enrollment to fall below the amount specified in Item 2 of the Declarations.

ARTICLE IX
GENERAL PROVISIONS

9.1 Limitation of Liability

Nothing herein contained shall interfere with the professional relationship between the Subscriber or Covered Dependent and a provider. In no instance shall the Company be liable for conduct, including but not limited to, tortious conduct, negligence or the wrongful acts or omissions of any provider or other professional practitioner or their agents or employees, in the provision or receipt of health care.

No agent has authority to change this Contract or waive any of its provisions.

9.2 Rights of Subscribers and Covered Dependents

The rights of each Subscriber to receive Benefits are outlined in the Declarations and Insuring Agreement Endorsement attached to this Contract. Nothing contained herein shall limit the right of the Company and the Group, which right is hereby expressly reserved, to amend or terminate this Contract, or to modify the appendixes hereto on a prospective basis from time to time, and any such amendment, termination and/or modification shall automatically be effective as against the Subscribers and Covered Dependents without notice to or consent of any Subscriber or Covered Dependent.

9.3 Entire Agreement

This Contract constitutes the entire agreement between the Company and the Group and may not be altered or amended except in writing, provided that specific Benefits and coverage options specified in the Declarations and insuring agreement endorsement may be modified upon agreement of both parties and will be effective not less than 60 days after the Company delivers updated Declarations and an Insuring Agreement Endorsement to the Group, except as otherwise required by law.

9.4 Endorsements

Nothing contained in any endorsement to the Contract shall affect any of the conditions, provisions, or limitations of the Contract, except as expressly provided in the endorsement. This Contract shall govern over any conflicting information provided by the Group to its employees and Subscribers.

9.5 Advertising and Promotion Control

The Company reserves the right to control the use of its name and all symbols, trademarks and service marks presently existing, or hereinafter established, with respect to it or to any Company Benefit option. The Group agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of the Company and will cease any and all usage immediately upon the Company's request or upon termination of this Contract.

9.6 Notices

Any request for change to any of the provisions of this Contract shall be in writing except as otherwise specifically provided herein. Such request is considered to be delivered when delivery is in person or when sent by registered or certified United States mail return receipt requested, proper postage prepaid, and properly addressed to:

For Dental Benefits:

Delta Dental of Wisconsin, Inc.
c/o President
P.O. Box 828
Stevens Point, WI 54481-0828

For Vision Benefits:

Wyssta Insurance Company, Inc.
c/o President
P.O. Box 85
Stevens Point, WI 54481-0085

9.7 Assignment

Neither party shall have the right to assign or otherwise transfer its rights or obligations under this Contract except with the prior written consent of the other; provided, however, that a successor in interest by merger, operation of law, assignment, purchase, or otherwise of the entire business of a party hereto shall acquire all interests of such party hereunder.

9.8 Legal Action

No suit at law or in equity shall be brought to recover upon any cause of action arising out of or relating to this Contract, or to Benefits provided hereunder, without exhausting Grievance procedures established by the Company, nor after the expiration of three years from the event upon which any such cause of action is based.

9.9 Governing Law

This Contract is delivered in the State of Wisconsin and is governed and construed under and pursuant to its laws.

9.10 Nonwaiver and Severability

No delay or failure by the Company to exercise any remedy or right accruing to it hereunder shall impair any such remedy or right or be construed to be a waiver of any such remedy or right, nor shall it affect any subsequent remedies or rights that the Company may have hereunder, whether or not the circumstances are the same.

The unenforceability or invalidity of any provision of this Contract as to any person or circumstances shall not render that provision or those provisions unenforceable or invalid as to any other person or circumstances, and in all other respects it and the remainder of this Contract shall remain valid and enforceable.

9.11 Rules and Regulations

The Company may, from time to time, establish such guidelines and processing policies as are reasonably necessary or appropriate to administer the Benefits provided under this Contract, and the Group agrees to be bound by any such rules and regulations.

9.12 Oral Statements

No oral statements of any person shall modify or otherwise affect the Benefits, limitations, conditions and exclusions of this Contract, convey or void any coverage, increase or reduce Benefits under the Contract, including the Certificate and the Schedule of Benefits, or be used in the prosecution or defense of a claim under this Contract.

9.13 Subrogation

If Benefits are paid on a Subscriber's or Covered Dependent's behalf under this Contract, the Company is entitled to all rights of recovery the Subscriber or Covered Dependent may have against any person or organization for the recovery of those Benefits to the extent of the Company's payment. The Company can only subrogate if the Subscriber or Covered Dependent is made whole for damages (is fully compensated for all damages, including any award for loss of employment, pain and suffering, taking into consideration the Subscriber's or Covered Dependent's comparative negligence). The Subscriber or Covered Dependent must sign and deliver to the Company any legal papers relating to that recovery, help exercise these rights of recovery and do nothing to harm these rights. If the Subscriber or Covered Dependent is made whole for all damages from another person or organization for Benefits paid or provided under this Contract, the Subscriber or Covered Dependent must repay the Company to the extent of Benefits paid or provided under this Contract.