

Ohio DentaTrust

Underwritten by Dental Care Plus, Inc.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE DENTAL CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DENTISTS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS.

NOTICE: THE STATE OF OHIO REQUIRES THAT WE PROVIDE YOU WITH THE FOLLOWING INFORMATION: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**Ohio DentaTrust Individual Dental Plan
Policy
Family Coverage**

[Policyholder: ¹[John Doe]]
Policy Number: ¹[XXXXXX]
Effective Date: ¹[01-01-2014]
Policy Anniversaries: ¹[January first of each year, beginning in 2015]

Dental Care Plus, Inc. certifies that the individuals covered under this Policy have the right to benefits for services according to the terms of this *Agreement*. This promise is based on the statements and agreements made in the application and payment of the required premiums. Please check your information for errors. An incorrect or incomplete application may cause this Policy to be voided and claims to be reduced or denied. This Policy is part of your *Agreement*.

Notice to Buyer: This is a Limited Benefit Policy. It provides benefits for dental treatment only.

This Policy is renewable. This Policy will be subject to renewal 12 months from the *effective date*, subject to our right to cancel as set forth in Part IV, Section 6. We reserve the right to change premium rates upon renewal of the Policy. If we do raise the premium rates, at least 60 days prior to the renewal date we will send written notice to your last known address shown on record.

ATTEST: Dental Care Plus, Inc.

²[/s/ Anthony A. Cook]
President & CEO

Contents

Introduction.....	Page ³ [4]
Subscriber’s Rights & Responsibilities.....	Page ³ [4]
Part I - Definitions	Page ³ [5]
Part II - Benefits.....	Page ³ [9]
Part III - Limitations and Exclusions	Page ³ [13]
Part IV - Effective Date, Enrollment and Disenrollment.....	Page ³ [15]
Part V - Other Contract Provisions.....	Page ³ [21]
Part VI - Filing a Claim.....	Page ³ [37]
Part VII - Index	Page ³ [39]
Schedule of Benefits	Provided Separately

Introduction

This Policy, including the attached *Schedule of Benefits*, the Application and any applicable Riders, Endorsements and Supplemental Agreements is the Agreement between you and Dental Care Plus, Inc. (The Plan). We urge you to read it carefully.

The dental services described in this Policy are covered as of your *effective date*, unless your benefits are subject to a waiting period. Additionally, there are some limitations and restrictions on your coverage. Please refer to the *Schedule of Benefits*, attached to this Policy, which outlines the specific coverage provided under your Policy. If you have any questions, please contact our Customer Service department.

This Policy permits you obtain your benefits from the dentist of your choice; however, if you chose to obtain your benefits from a non-contracting dentist, your out of pocket expenses, including your copayments and deductible, will be higher. See the Schedule of Benefits for the difference in coinsurance and deductible amounts for benefits received from a non-contracting dentist.

Subscriber's Rights and Responsibilities

As a Dental Care Plus subscriber, you have the right to:

- File a *complaint* or *appeal* about the dental services provided to the covered individuals.
- Be provided with appropriate information about the Plan and its benefits, *contracting dentists*, and policies.

You and covered individuals have the responsibility to:

- Ask questions in order to understand your dental condition and treatment, and follow recommended treatment instructions given by your dentist.
- Provide information to your dentist that is necessary to render care to you.
- Be familiar with the Plan benefits, policies and procedures, by reading our written materials, or calling our Customer Service department.

Part I - Definitions

ACA: The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148).

Adverse determination: a utilization review decision by the *Plan*, or a *health care provider* acting on behalf of the *Plan* that:

- a) decides a proposed or delivered *health care service* which would otherwise be covered under the *covered individual's* Policy is not, or was not medically necessary, appropriate, or efficient; and
- b) may result in non-coverage of the *health care service*.

Adverse determination does not include a decision concerning a *subscriber's* status as a member.

Agreement: refers to this Policy, *Schedule of Benefits*, Application, and any applicable Riders, Endorsements and Supplemental Agreements.

Appeal: an appeal filed by a *covered individual*, *covered individual's representative* or a *health care provider* with *the Plan* under its internal *appeal* process of an adverse determination or a *coverage decision* concerning a *covered individual*.

Appeal Decision: a final determination by *the Plan* that arises from an *appeal* filed with *the Plan* under its *appeal* process regarding an adverse determination or a *coverage decision* concerning a *covered individual*.

Benefit Period: the twelve (12) month period for which any applicable *deductibles* or maximums apply. This twelve (12) month period is the plan year.

Carry-forward deductible: any portion of the *deductible* amount that is satisfied during the last three months of the calendar year and is carried forward and applied to the following year's *deductible*.

Coinsurance: the percent of covered dental expenses, after the *deductible* is satisfied, which the covered individual must pay, up to the maximum covered charge shown in the *Schedule of Benefits*.

Complaint: a protest filed with the state of Ohio involving an *adverse determination* or a *coverage decision* concerning a *covered individual*.

Contracting Dentist: a licensed dentist who has entered into an agreement, either directly or through a network which contracts with *the Plan*, to furnish services to its *covered individuals* and who participates in the designated network for *the Plan*. A contracting dentist is sometimes referred to in this Policy as an In-network dentist. The designated network for *the Plan* is described in the Provider Directory for *the Plan* and is available at Hixfad.dentalcareplus.com]

Coverage decision: an initial determination by *the Plan*, or a representative of *the Plan* that results in noncoverage of a *health care service*. *Coverage decision* includes nonpayment of all or any part of a claim, but does not include an *adverse determination* as defined above.

Covered dependents: See *Family coverage* definition.

Covered individual: a person who is eligible for dental benefits under this Policy, and has enrolled under the Policy as described in the Enrollment sections below. This usually includes *subscribers* and their *covered dependents*.

Covered individual's representative: An individual who has been authorized by the *covered individual* to file an *appeal* or a *complaint* on the *covered individual's* behalf.

Date of service: The actual date that the service was completed. With multi-stage procedures, the *date of service* is the final completion date (the insertion date of a crown, for example).

Deductible: the portion of the covered dental expenses that the *covered individual* must pay before *the Plan's* payment begins. This deductible is shown in the *Schedule of Benefits*.

Dentist: any dental or medical practitioner the *plan* is required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Policy.

Effective Date: the date, as shown on our records, on which your coverage begins under this Policy or an amendment to it.

Emergency medical condition: a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867 (e)(1)(B) of the Social Security Act, 42 USC section 1395dd(e)(1)(B). Emergency dental care includes treatment to relieve acute pain or control a dental condition that requires immediate care to prevent permanent harm.

Exchange: the federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the ACA, codified as 42 U.S.C. § 18041(c).

Family coverage: coverage that includes the subscriber, the subscriber's legally married spouse and unmarried dependent children from the moment of birth up to nineteen (19) years of age. Dependent children include (i) biological children; (ii) children named in a divorce decree or qualified medical child support order as being the responsibility of the subscriber for dental benefits coverage; (iii) legally adopted children, foster children, or children for which the subscriber has legal custody; (iv) children who have been placed for adoption with the subscriber, if legal adoption is anticipated but not yet finalized; (v) children of any age who are incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 19. The subscriber must principally support the disabled dependent child and proof of the permanent disability must be submitted to Dental Care Plus. All dependent children, as defined above, should also be eligible to be claimed as a dependent for the purposes of the Internal Revenue Service, and principally reside with the subscriber. Enrollment, however, shall not be denied if the Internal Revenue Service and or/residency conditions are not satisfied. In no event shall this coverage include a person on active duty in any military service of any country.

Fee schedule: the payment amount for the services that may be provided by *contracting dentists* under this Policy. Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this Policy and in effect at the time services are rendered.

Filing date: the earlier of a.) five (5) days after the date of mailing; or b.) the date of receipt.

Fracture: the breaking off of rigid tooth structure not including crazing due to thermal changes or chipping due to attrition.

Health care provider: a.) an individual who is licensed under the Ohio law to provide *health care services* in the ordinary course of business or practice of a profession and is a treating provider of the *covered individual*; or b.) a hospital, as defined in the Ohio Revised Code.

Health care service: a health or medical care procedure or service rendered by a *health care provider* that: a.) provides testing, diagnosis, or treatment of a human disease or dysfunction; or b.) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction.

Individual (or single) coverage: coverage that includes only the *subscriber*.

Injury: (1) all damage to the *covered individual's* mouth due to an accident which occurs while he or she is covered by this Policy; and (2) all complications arising from that damage. But, the term does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

Inquiry: any question or concern which has not been the subject of an *adverse determination* or a *coverage decision*.

Non-Contracting Dentist: a licensed dentist who has not entered into an agreement with *the Plan* to furnish services to its *covered individuals*. A non-contracting dentist is sometimes referred to in this Policy as an out-of network dentist.

Plan year deductible: this *deductible* must be satisfied each plan year.

Out of Area Emergency: the sudden onset of dental pain, trauma, or bleeding while traveling outside the service area that could not have been predicted.

Out of Pocket Maximum: the maximum a *covered individual* will pay in *deductibles*, copays and *coinsurance* for allowable expenses in any calendar year.

Schedule of Benefits: the part of this Policy which outlines the specific coverage in effect as well as the amount, if any, that you may be responsible for paying towards your dental care.

Schedule of Maximum Covered Charges: see *Fee Schedule*.

Subscriber: the Policyholder who is eligible to receive dental benefits. A parent or guardian enrolling a minor dependent, assumes all of the subscriber responsibilities on behalf of the minor dependent.

The Plan: refers to Dental Care Plus, Inc.

Utilization Review: a system for reviewing the appropriate and efficient allocation of *health care services* given or proposed to be given to a patient or group of patients.

You: the *subscriber* of the dental *plan*.

Part II

Benefits

Covered individuals have the right to benefits for the following services, EXCEPT as limited or excluded elsewhere in this Policy. Some benefits may be limited to a maximum dollar payment for each *covered individual* for each *benefit period* shown in the *Schedule of Benefits*. The extent of your benefits is explained in the *Schedule of Benefits* which is incorporated as a part of this Policy.

Class I

Diagnostic and Preventive Services (Please see the *Schedule of Benefits* for frequency and limitations for the coverage you have purchased.)

Benefits are available for the following dental services to diagnose or to prevent tooth decay and other forms of oral disease. These dental services are what most Covered Individuals receive during a routine preventive dental visit. Examples of these services include:

Initial oral examination (including the initial dental history and charting of teeth); once per dentist.

Periodic exam; once every six (6) months.

X-rays of the entire mouth; once every sixty (60) months.

Bitewing x-rays (x-rays of the crowns of the teeth); once every six (6) months when oral conditions indicate need.

Single tooth x-rays; as needed.

Oral and facial photographic images;

Study models and casts used in planning treatment;

Routine cleaning, scaling and polishing of teeth; once every six (6) months.

Fluoride treatment, Topical Fluoride - Varnish - age 19 and over - 1 in 12 months, under age 19 - 2 every 12 months, Topical application of fluoride (excluding prophylaxis) – under age 19 - 2 every 12 months.

Space maintainers required due to the premature loss of teeth; only for children under age nineteen (19) and not for the replacement of primary or permanent anterior teeth.

Sealants on unrestored permanent molars, under age 19; 1 sealant per tooth every 36 months.

Class II

Restorative Services and Other Basic Services (Please see the *Schedule of Benefits* for frequency and limitations for the coverage you have purchased.)

Benefits are available for the following dental services to treat oral disease including: (a) restore decayed or fractured teeth; (b) repair dentures or bridges; (c) rebase or reline dentures; (d) repair or recement bridges, crowns and onlays; and (e) remove diseased or damaged natural teeth. Examples of these services include:

Fillings consisting of silver amalgam and (in the case of front teeth) synthetic tooth color fillings. However, synthetic (white) fillings are limited to single surface restorations for posterior teeth. Multi-surface synthetic restorations on posterior teeth will be treated as an alternate benefit and an amalgam allowance will be allowed. The patient is responsible up to the dentist's charge.

Sedative fillings.

Stainless steel crowns, under age 19 - Limited to 1 per tooth in 60 months.

Simple tooth extractions.

General anesthesia only when necessary and appropriate for covered surgical services only when provided by a licensed, practicing dentist.

Repair of dentures or fixed bridges. Recementing of fixed bridges.

Rebase or reline dentures; once every thirty-six (36) months, 6 months after initial installation.

Tissue conditioning.

Repair or recement crowns and onlays.

Adding teeth to existing partial or full dentures.

Palliative (emergency) treatment of dental pain – minor procedures.

Periodontal maintenance, 4 in 12 months, following active periodontal therapy

Class III

Complex Dental Services (Please see the *Schedule of Benefits* for frequency and limitations for the coverage you have purchased.)

Benefits are available for the following dental services and supplies to treat oral disease including: replace missing natural teeth with artificial ones; remove diseased or damaged natural teeth; and restore severely decayed or fractured teeth. Examples of these services include:

Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.

Periodontal services to treat diseased gum tissue or bone including the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). Periodontal benefits are determined according to our administrative "Periodontal Guidelines."

Endodontic services for root canal treatment of permanent teeth including the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.

Dentures and Bridges

- Complete or partial dentures and fixed bridges including services to measure, fit, and adjust them; once each sixty (60) months.
- Replacement of dentures and fixed bridges, but only when they cannot be made serviceable and were inserted at least sixty (60) months before replacement.

Crowns, Onlays and Inlays

Crowns, onlays and inlays as follows, but only when the teeth cannot be restored with the fillings due to severe decay or fractures:

- Initial placement of crowns, onlays and inlays.
- Replacement of crowns, onlays and inlays; once each sixty (60) months per tooth.

Implants

An **implant** is a covered procedure of the plan only if determined to be a dental necessity. Claim review is conducted by a panel of licensed dentists who review the clinical documentation submitted by your treating dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no benefits will be allowed for the individual implant or implant procedures. Only the second phase of treatment (the prosthodontic phase-placing of the implant crown, bridge denture or partial denture) may be subject to the alternate benefit provision of the plan. An implant is a covered service only for dependents under age 19.

Occlusal guards; 1 in 12 months for patients between the ages of 13 and 18.

Class IV

ORTHODONTIC SERVICES (under age 19)

Medically Necessary Orthodontics

- Medically necessary coverage for orthodontic care. Medical necessity is determined upon review of case submission for prior authorization. Orthodontic services for severe and handicapping malocclusion as defined by HLD index score of 28 and/or one or more auto qualifier. Orthodontic services require prior authorization.

Part III

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE SERVICES

We will not provide benefits for a dental service that is not covered under the terms of the Policy. We will not provide benefits for a covered dental service that is not necessary and appropriate to diagnose or to treat your dental condition. We will not cover experimental care procedures that have not been sanctioned by the American Dental Association and for which no procedure codes have been established.

A. To be necessary and appropriate, a service must be consistent with the prevention of oral disease or with the diagnosis and treatment on (1) those teeth that are decayed or *fractured* or (2) those teeth where supporting periodontium is weakened by disease in accordance with standards of good dental practice not solely for your convenience or the convenience of your dentist.

B. Who determines what is necessary and appropriate under the terms of the Policy: That decision is made by *the Plan* based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the Policy even if your dentist has furnished, prescribed, ordered, recommended or approved the service.

2. WE DO NOT PROVIDE BENEFITS FOR:

- Experimental care procedures that have not been sanctioned by the American Dental Association, or for which no procedure codes have been established.
- A service or procedure that is not described as a benefit in this Policy.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Travel time and related expenses.
- An illness or injury that we determine arose out of and in the course of your employment.
- A service for which you are not required to pay, or for which you would not be required to pay if you did not have coverage under this Policy.
- An illness, injury, or dental condition to the extent for which benefits are provided in one form or another through a government program. It does not include Medicaid or Medicare.
- A method of treatment more costly than is customarily provided. Benefits will be based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or dentists who are salaried employees of a hospital or other facility.
- Appointments with your dentist that you fail to keep.
- Dietary advice and instructions in dental hygiene including proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.

- A service rendered by someone other than a licensed dentist or a hygienist who is employed by a licensed dentist.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.
- Services that are meant primarily to change or to improve your appearance.
- Repair or relines of an occlusal guard.
- Implants, age 19 and over
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth when required due to periodontal disease such as periodontal splinting.
- Lab exams.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Stainless steel crowns on permanent teeth.
- Cast restorations, copings and attachments for installing over dentures.
- Services related to congenital anomalies. However, this exclusion does not apply to any covered orthodontic services.
- Tooth desensitization.
- Occlusal adjustment.

Part IV

Effective Date, Enrollment and Disenrollment

1. WHEN YOUR COVERAGE BEGINS

The dental services described in this Policy are covered as of the *effective date* of the Policy, as set out in the Application unless benefits are subject to a waiting period.

2. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to the Policy are allowed **ONLY** when they conform to our Underwriting Guidelines. Coverage for new spouses shall be effective from the date of marriage if notice is provided on a timely basis. Newly born children, newly adopted dependent children or grandchildren shall be covered from the moment of birth or date of adoption, if notice is provided on a timely basis. The date of adoption shall be the earlier of a judicial decree of adoption or the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent, including any child placed with you for adoption and any child for whom you are a party in a suit in which the adoption of the child is sought. A minor for whom guardianship is granted by court or testamentary appointment shall be covered from the date of appointment, if notice is provided on a timely basis. A child, who the court orders to be covered under a *subscriber's* dental coverage, shall be covered from the date of the order, if notice is provided on a timely basis.

Changes to the Policy may result in a change in your premium. If additional payments of premium are required to provide coverage for the newly dependent spouse or children, you must notify the *Plan* within thirty-one (31) days after the date of marriage, birth, adoption or other court order or testamentary appointment. You may be required to submit proof of the court order or relationship to the *Plan*.

3. ENROLLING DEPENDENTS

Under certain situations, dependents may be added to your coverage at any time. Qualifying events could be a result of court order, involuntary employment termination, and your spouse's death. Under those circumstances, you must notify the *Plan* within thirty (30) days of the qualifying event.

- a. Death of Spouse – If your spouse dies, you may add your dependent child(ren) to the coverage provided under this *Agreement* at any time and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's Policy.
- b. Court Order – If you are required under a court order (whether from this state or another state that recognizes the right of the child to receive benefits under

the *subscriber's* health coverage) to provide health coverage for a child, the *Plan* shall allow you to enroll the child under the following circumstances:

1. You shall be allowed to enroll in family members' coverage and include the child in that coverage regardless of any enrollment period restrictions.
2. If you are enrolled but do not include the child in the enrollment, we shall allow the noninsuring parent of the child, child support enforcement agency, or any other agency with authority over the welfare of the child to apply for enrollment on behalf of the child.
3. You may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect, that the child is or will be enrolled under other reasonable dental coverage that will take effect on or before the *effective date* of termination

4. ENROLLMENT THROUGH THE EXCHANGE AND PREMIUM PAYMENTS

Notwithstanding the requirements of Part IV, Sections 2 and 3 of this Policy, if coverage is obtained through the *Exchange*, the *Exchange* will enroll qualified individuals and enrollees and terminate coverage in accordance with the requirements of the ACA, the rules promulgated under the ACA, including Parts 155 and 156 of Title 45 of the Code of Federal Regulations, and the requirements of the *Exchange*. The open and special enrollment periods and effective dates of coverage in 45 C.F.R. §§ 155.410 and 155.420 will apply with respect to enrollment through the *Exchange*.

The *Plan* is required to process enrollments in accordance with 45 CFR 156.265, which requires the *Plan* to enroll an individual only if the *Exchange* notifies the *Plan* that the individual is a qualified individual as determined by the *Exchange*.

For coverage obtained through the *Exchange*, premium payments will be required to be made directly to the *Plan* in accordance with the *Plan's* available methods for payment. The first premium payment will be due prior to the effective date of coverage, and premiums will be due monthly thereafter unless a different payment interval is permitted by the *Plan*.

a. Initial and annual open enrollment periods.

1. Initial open enrollment period. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

2. Effective coverage dates for initial open enrollment period For a Qualified Health Plan ("QHP") selection received by the *Exchange* from a qualified individual—

a) On or before December 15, 2013, the coverage effective date is January 1, 2014;

b) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, the coverage effective date is the first day of the following month; and

c) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the coverage effective date is the first day of the second following month.

3. Notice of annual open enrollment period. Starting in 2014, the *Exchange* will provide you with a written annual open enrollment notification no earlier than September 1, and no later than September 30.

4. Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.

5. Effective date for coverage after the annual open enrollment period. Coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

b. Special enrollment periods.

1. Special enrollment period triggering events. You may enroll in or change from one QHP to another as a result of the following triggering events:

- a) You or your dependent loses minimum essential coverage;
- b) You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption;
- c) You gain status as a citizen, national, or lawfully present individual;
- d) Your enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the *Exchange* or HHS, or its instrumentalities as evaluated and determined by the *Exchange*. In such cases, the *Exchange* may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- e) You adequately demonstrate that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you;
- f) You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a QHP. The *Exchange* will permit individuals whose existing

coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

g) You or gain access to new QHPs as a result of a permanent move;

h) If you are an Indian, as defined by section 4 of the Indian Health Care Improvement Act, you may enroll in a QHP or change from one QHP to another one time per month; and

i) You demonstrate to the *Exchange*, in accordance with guidelines issued by HHS, that you meet other exceptional circumstances as the *Exchange* may provide.

2. Length of special enrollment periods. Unless specifically stated in the applicable rules, you have 60 days from the date of a triggering event to select a QHP.

3. Effective dates.

a) Regular effective dates. Unless an exception applies, for a QHP selection received by the *Exchange*—

i) Between the first and the fifteenth day of any month, your coverage effective date will be the first day of the following month; and

ii) Between the sixteenth and the last day of any month, your coverage effective date will be the first day of the second following month.

b) Special effective dates.

i) In the case of birth, adoption or placement for adoption, your coverage is effective on the date of birth, adoption, or placement for adoption, but advance payments of the premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

ii) In the case of marriage, or in the case where you lose minimum essential coverage, your coverage is effective on the first day of the following month.

5. WHEN YOUR COVERAGE ENDS

A *covered individual* will not be eligible for coverage when any of the following occurs:

- A. The *subscriber* is no longer enrolled.
- B. A dependent child under *family coverage* attains the limiting age for coverage (please see Part 1 for the definition of *Family Coverage* and eligibility requirements for dependents).
- C. The spouse of the subscriber becomes divorced or legally separated

Benefits will be provided in accordance with the Policy in effect at the time an individual's coverage terminates, for a course of treatment for at least 90 days after the date coverage terminates if the treatment: (i) begins before the date coverage terminates; and (ii) requires two or more visits on separate days to a dentist's office.

6. TERMINATION OF A POLICY.

You may cancel this Policy as set forth in this section.

The following termination rules apply when you cancel coverage obtained through the *Exchange*.

1. If you provide us with notice at least fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the termination date specified by you in the notice of termination.
2. If you provide us with notice less than fourteen (14) days prior to the proposed effective date of termination, the last day of coverage is the date determined by us, if we are able to effectuate termination in fewer than fourteen (14) days and you request an earlier termination effective date. If we are unable to effectuate termination in fewer than fourteen (14) days, termination will be effective fourteen (14) days from the date of notice. If you are newly eligible for Medicaid or a Children's Health Insurance Program, the last day of coverage is the day before such coverage begins.

The following termination rules apply if coverage is obtained other than through the *Exchange*.

You may cancel this Policy for any reason. To do so, we request you give us notice in writing at least thirty (30) days prior to the termination date.

B. *The Plan* may cancel this Policy.

1. We may, upon thirty (30) days notice to *you*, cancel this Policy under any of the following circumstances:
 - a) We may cancel this Policy, subject to the Contestability of Coverage provision set forth in Part V, Section 13, if you make any fraudulent claim or material

misrepresentation to us or to any dentist, such as an incorrect or incomplete statement on your application, which led us to believe you were eligible for this coverage when in fact you were not. In such a case, cancellation will be as of your *effective date*. We will refund you the premium you have paid us. We will subtract from the refund any payments made for claims under this Policy. If we have paid more for claims under this Policy than you have paid us in premium, we have the right to collect the excess from you.

- b) We may cancel this Policy if you have not paid your premium, subject to the Grace Period provision under Part V, Section 15 of this Policy.
- c) We may cancel this Policy if we decide to withdraw this product from the *Exchange*, in which case you will be offered a replacement policy.
- d) We may cancel this Policy if we withdraw entirely from the *Exchange's* individual market.

If coverage is obtained through the *Exchange*, terminations will be initiated by the *Exchange*, except for terminations for nonpayment of premium which will be initiated by the *Plan*.

C. Cancellation due to loss of eligibility

This Policy will be canceled if you are no longer eligible because you no longer reside in Ohio. The termination date of this coverage shall be the last day of the month in which we were notified of your move and for which the premium has been paid.

For information regarding benefits after cancellation see Part IV, Section 17 of this Policy.

Part V

Other Contract Provisions

1. BENEFIT PAYMENTS

IN-NETWORK SERVICES:

If a *covered individual* uses the services of a *contracting dentist*, the in-network benefit allowance is based on the fee schedule that the *contracting dentist* has agreed to accept as payment in full for the dental services listed in the benefits section, except as provided under item 2 below. The *Plan* pays the *contracting dentist* directly for covered services.

OUT-OF-NETWORK SERVICES:

If a *covered individual* uses the services of a *non-contracting dentist*, covered dental services are the percentage of maximum allowable charges for the dental services listed in the benefits section.

2. WHEN YOUR *CONTRACTING DENTIST* MAY CHARGE YOU MORE

When your *Contracting Dentist* provides covered services, he or she must accept the fee in the fee schedule as payment in full. But in the following cases you will be responsible for the difference between *the Plan* payment and the dentist's actual charge for covered services:

- A. If you have received the maximum benefit allowed for services. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum.
- B. If you and your dentist decide to use services that are more expensive than those customarily furnished by most dentists, benefits will be provided based on the service with the lower fee.
- C. If you receive payment from another person or his or her insurance company for injuries he or she caused.
- D. If, for some reason, you receive services from more than one dentist for the same dental procedure or receive services that are furnished in a series during a planned course of treatment. In such a case the total amount of your benefit will not be more than the amount that would have been provided if only one dentist had furnished all the services.

3. PRE-TREATMENT ESTIMATES

If your dentist expects that dental treatment will involve a series of covered services (over \$600), he or she should file a copy of the treatment plan with *the Plan* BEFORE these services are rendered to a *covered individual*. A treatment plan is a detailed description of the procedures that the dentist plans to perform and includes an estimate of the charges for each service.

Upon receipt of the treatment plan, we will notify you and your dentist about the maximum extent of your benefits for the services reported

The pre-treatment estimate of benefits is valid for 90 days after the date we notify *you*, your *covered dependents* and the dentist of the benefits payable for the proposed treatment plan. If treatment is to commence more than 90 days after the date we notify *you*, your *covered dependents* and the dentist of the benefits payable for the proposed treatment plan, a new treatment plan may be submitted.

IMPORTANT NOTE: Pre-treatment estimates are calculated based on current available benefits and the patient's eligibility. Estimates are subject to modification and eligibility that applies at the time services are completed and a claim is submitted for payment. The pre-treatment estimate is NOT a guarantee of payment or a preauthorization.

4. WHEN YOUR *CONTRACTING DENTIST* IS TERMINATED

If the *Contracting Dentist* is terminated for any reason other than fraud, patient abuse, incompetency or loss of license status, he/she shall continue to provide dental services to complete the procedure(s) in progress for at least ninety (90) days from the date of notice of termination, as if his/her *Contracting Dentist Agreement* with *the Plan* was still in effect. The *Plan* will compensate the dentist for such services in accordance to the terms set forth in the *Contracting Dentist Agreement*.

If the *Contracting Dentist* terminates the *Contracting Dentist Agreement*, the *Contracting Dentist* shall continue to provide, for at least ninety (90) days after the date of notice of termination to *the Plan*, dental care services to a *covered individual* of the *Plan* for whom the *Contracting Dentist* was responsible for the delivery of dental care services prior to the notice of termination. The *Contracting Dentist* will provide orthodontic treatment begun when coverage was in effect, at the rates set forth in the *Contracting Dentist Agreement*.

5. BENEFIT PAYMENTS FOR SERVICES BY *NON-CONTRACTING DENTISTS*

A. If you receive services from a *Non-contracting Dentist*, you may be required to pay more out of pocket than for services provided by most *Contracting Dentists*. Benefits for covered services provided by a *Non-contracting Dentist* are based on the lesser of the dentist's submitted fee or the payment amount for services that may be provided by Participating or *Non-contracting Dentists* as indicated on the *Fee Schedule*. In addition, *you* will be responsible for paying any difference between *the Plan's* payment to a *Non-contracting dentist*, after any deductible or coinsurance amounts are calculated based on the maximum allowable charge as indicated on the *Fee Schedule*, and the *Non-contracting Dentist's* total charge, if his/her total charge exceeds the *Fee*

Schedule amount for that covered procedure(s). Benefits are payable in accordance with the terms and conditions of the applicable *Schedule of Benefits* attached to this Subscriber Policy and in effect at the time services are rendered.

- B. A *covered individual* may request a referral to a specialist who is a *Non- contracting Dentist* if a.) a *covered individual* is diagnosed with a condition or disease that requires specialized dental care; and b.) *the Plan* has not contracted with a specialist with the professional training and expertise to treat the condition or disease; and, c.) the specialist agrees to be reimbursed the same allowed benefit as would be provided to a specialist who is a *Contracting Dentist*.

If a *Contracting Dentist* refers the *covered individual* to a specialist who is not a *Contracting Dentist* for dental services that are covered under the Subscriber Certificate, *the Plan* will be responsible for payment of the specialist's charges that exceed the co-payment specified in the Subscriber Policy.

To find out if your dentist participates with *the Plan* ask your dentist if he or she has an agreement with us, call our Customer Service department, visit our website, or check the directory of *Contracting Dentists*.

6. EMERGENCY CARE

All dental expenses for emergency services are paid as any other expense. Nothing in this Policy of coverage will prohibit a *covered individual* from seeking emergency care whenever the individual is confronted with an *emergency medical condition* which in the judgment of a prudent layperson would require pre-hospital emergency services. This includes the option of calling the local pre-hospital emergency medical services system by dialing 911, or its local equivalent. Emergency dental care is defined in Part I. If you utilize the dental services of a *non-contracting dentist*, benefits will be paid under the out-of-network *Plan* benefits described in item 1 above.

7. SUBROGATION

A *covered individual* may have a legal right to recover some costs of your dental care from someone else because another person has caused your illness or injury. When a *covered individual* has this right, the covered individual must allow *the Plan* the right to recover any payments it has made for the illness or injury. If a *covered individual* recovers money from someone else, *the covered individual* must repay *the Plan* for the payments that it has made. *The Plan's* right to repayment comes first. The repayment amount can be reduced only by the *Plan's* share of your reasonable cost of collecting the claim against the other person, or if the payment received is described as payment for other than dental expenses. A *covered individual* is obligated to provide *the Plan* with the written authorization, information and assistance necessary to help the *Plan* recover its payment, and must not do anything to prohibit *the Plan* from collecting its repayment.

8. WE MUST HAVE ACCESS TO YOUR DENTAL RECORDS AND/OR OTHER RELEVANT RECORDS

You agree that when you claim benefits under this Policy, you give us the right to obtain all dental records and/or other related information that we need from any source for claims processing purposes. This information will be kept strictly confidential and is subject to federal and state privacy and confidentiality regulations.

Contracting Dentists have agreed to give us all information necessary to determine your benefits under this Policy and have agreed not to charge for this service.

9. PREMIUM

The amount of money that you are responsible for paying to the *Plan* for your benefits under this *Agreement* is called your premium. We will send you a notice at least sixty (60) days before any change in your premium goes into effect. Your premium will not change more than once every twelve (12) months.

10. WE MAY CHANGE YOUR POLICY

We will send a notice each time we change all or part of your Policy, describing the change(s) being made. Changes to the Policy may include the addition or deletion of riders as well as plan design changes. You can also call our Customer Service department to get information on your *plan* change. Our telephone number is listed at the end of this Policy.

The notice will tell you the *effective date* of the change and the benefits for services you may receive on or after the *effective date*. There is one exception: If before the *effective date* of the change, you started receiving services for a procedure requiring two or more visits, we will not apply the change to services related to that procedure.

11. REINSTATEMENT

If any premium is not paid within the required time period, coverage for you and any of your covered dependents will lapse. If we later accept a premium payment without requiring an enrollment for reinstatement, this Policy will be reinstated with such payment. If enrollment for reinstatement is required, the coverage will be reinstated when we approve your enrollment for reinstatement.

If the coverage is reinstated, any losses resulting from an injury will be covered only if the injury is sustained on or after the date of reinstatement.

In all other respects, we as well as you and your covered dependents will have the same rights as existed under this Policy before the coverage lapsed, subject to any provisions included with or attached to this Policy in connection with the reinstatement.

12. MISSTATEMENT OF AGE

If the age of the *subscriber*, or any of the *subscriber's* covered *dependents* has been

misstated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age.

13. CONTESTABILITY OF COVERAGE

All statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties, and no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application.

14. BENEFITS AFTER CANCELLATION

If you cancel your Policy or if we cancel your Policy for any reason other than material misrepresentation, no benefits will be provided for services that you receive after the cancellation date, except as set forth in this section.

Benefits will be provided for a course of treatment for 90 days after the date coverage terminates if the treatment: (i) begins before the date coverage terminates; and (ii) requires two or more visits on separate days to a dentist's office.

15. GRACE PERIOD

A grace period of thirty-one (31) days will be granted for payment of each premium payment due after the first premium payment. During the grace period, the *Agreement* shall continue in force. If a *subscriber* is receiving advance payments of the premium tax credit under the ACA, and the *subscriber* has previously paid at least one full month's premium during the *Benefit Year*, the grace period is extended to three (3) consecutive months.

16. NOTICES

- A. To you: When we send a notice to you by first class mail. Once we mail the notice or bill we are not responsible for its delivery. This applies to a notice of a change in the premium or a change in the Policy. If your name or mailing address should change, you should notify the *Plan*. Be sure to give the *Plan* your old name and address as well as your new name and address.
- B. To us: Send letters to ⁵ [Dental Care Plus, Inc., 100 Crowne Point Place, Cincinnati, OH 45241]. Always include your name and *subscriber* identification number.

17. WHEN AND HOW BENEFITS ARE OBTAINED AND PROVIDED

This Policy is designed to provide high quality dental care while controlling the cost of such care. To do this, this Policy encourages the *covered individual* to seek dental care from *contracting dentists* and in-network facilities, however, you are free to select the *dentist* of your choice. When application is made under this Policy, the *covered individual* receives a welcome packet which includes a dental plan identification card.

Benefits will be provided ONLY for those covered services that are furnished on or after the *effective date* of this *contract*. If before a *subscriber's effective date* he or she started

receiving services for a procedure that requires two or more visits, NO BENEFITS are available for services related to that procedure. In order for you to receive any of the benefits for which you may have a right, you must inform your *dentist* that you are a *covered individual* and supply him or her with your *subscriber* identification number and any necessary information needed to file your claim. If you fail to inform your *dentist* within twelve (12) months after the services are rendered, we will no longer be obligated to provide any benefits for those services.

18. WE ARE NOT RESPONSIBLE FOR THE ACTS OF DENTISTS

We will not interfere with the relationship between dentists and patients. You are free to select any dentist. It is your responsibility to find a dentist. We are not responsible if a dentist refuses to furnish services to you. We are not liable for injuries or damages resulting from the acts or omissions of a dentist.

19. COORDINATION OF BENEFITS

The Coordination of Benefits (“COB”) provision applies when a person has health care coverage under more than one plan. ”Plan” is defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

DEFINITIONS

A. For purposes of this section, a “plan” is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) “Plan” includes: group and nongroup insurance contracts, health insuring corporation (“HIC”) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) “Plan” does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

B. "This Plan" means, in a COB provision, the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether this Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

D. For purposes of this section, "allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

(2) If a Subscriber is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. “Closed panel plan” is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. “Custodial parent” is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other plan.

B. (1) Except as provided in Paragraph (2), a plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

(1) Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent;

- The plan covering the spouse of the custodial parent;

- The plan covering the non-custodial parent; and then

- The plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Ohio DentaTrust may get the facts it needs from or give them to other organizations or persons for the purpose

of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. Ohio DentaTrust need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Ohio DentaTrust any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, Ohio DentaTrust 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. Ohio DentaTrust will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Ohio DentaTrust is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION DISPUTES

If You believe that we have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at 1-855-343-4263 or www.dentaquest.com. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>.

20. RIGHT TO RECOVER OVERPAYMENTS

If we pay more than we should have under COB, then you must refund any overpayment to *the Plan*.

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those already described in the Benefits Section of this Policy. Remember that under COB, the total of the payments made for covered *health care services* will not be more than the total of the allowed charges for those covered services. We will not provide duplicate benefits for the same services. If you have any questions about COB and your Policy, please contact our Customer Service department. The telephone number is listed at the end of this Policy.

21. CHOICE OF LAW

This Policy shall be construed according to the laws of the State of Ohio. This Policy may be automatically revised in order to conform to statutory requirements of the laws of the State of Ohio.

22. LEGAL ACTIONS

No action in law or equity will be brought to recover under this *contract* prior to sixty (60) days after a claim has been presented to us, nor will any such action be brought unless brought within three (3) years from the expiration of the time within such claim submission is required.

23. ENTIRE AGREEMENT; CHANGES

This Policy, including the attached *Schedule of Benefits*, the Application, and any applicable Riders, Endorsements and Supplemental Agreements constitutes the entire *contract*. No change in this Policy shall be valid until approved by an officer of *the Plan* and unless such approval be endorsed hereon or attached hereto. No agent has any authority to change this Policy or to waive any of its provisions.

24. COMPLAINT AND APPEAL PROCEDURES

NOTE: *The Plan*, as used in these *appeals* procedures shall mean [Dental Care Plus, Inc. c/o DentaQuest, LLC, at 12121 North Corporate Parkway, Mequon, WI 53092]. The Plan has delegated its internal *appeals* process to DentaQuest.

1. Complaint Procedures

The Plan recognizes its responsibility to provide *covered individuals* with adequate methods to make inquiries and express concerns about *the Plan*. The following procedure has been established to assure that the *covered individual* will receive a response to any complaint and formal redress if appropriate.

A complaint is an oral or written expression of dissatisfaction. A complaint can be made by contacting the Customer Service Department of *Plan*. The *covered individual* may contact Customer Service in writing, by telephone or in person. Customer Service will attempt to resolve the complaint through informal discussions, consultations, or conferences, and will notify the *covered individual* of its decision within ten (10) working days following receipt of the complaint.

If your complaint involves a decision by *the Plan* on a claim or pretreatment estimate to deny, reduce or terminate benefits, you also have the right to file an appeal. Although you are not required to file a complaint before appealing a decision by *the Plan*, you are encouraged to do so because some issues may be quickly resolved without the need for an appeal. The procedure for filing an appeal is described in the Appeal Procedures section. If your complaint does not involve a decision by *the Plan* on a claim or pretreatment estimate to deny, reduce or terminate benefits, you are not entitled to file an appeal, but you do have the right to ask the Ohio Department of Insurance to review your complaint as described in the section on Complaints to the Ohio Department of Insurance.

2. Appeal Procedures

An appeal is a request to change a previous decision by *the Plan* on a claim or pretreatment estimate to deny, reduce or terminate benefits. An appeal must be filed in writing within 180 days following your initial receipt of notice that benefits for a claim or pretreatment estimate have been denied, reduced or terminated. Appeals filed later than 180 days following your initial receipt of such notice, will be denied. All appeals must be submitted in writing. If

your appeal is of a claim for urgent treatment, you may orally request an expedited appeal, but you must follow-up your oral request in writing. Your appeal will be expedited if you (1) are hospitalized or (2) in the opinion of the treating Dentist, review under a standard timeframe could, in the absence of immediate medical attention, result in:

- Placing your health, or if you are a pregnant woman, the health of your unborn child in serious jeopardy; or
- Serious impairment to bodily function or serious dysfunction of a bodily organ or part.

An appeal may be filed by you, your dentist or by an Authorized Person acting on your behalf. An “Authorized Person” is a parent, guardian, or other person authorized to act on behalf of a Covered Individual with respect to health care decisions.

In order to file an appeal, send a letter to:

[Ohio DentaTrust Dental Plan
c/o DentaQuest , LLC
12121 North Corporate Parkway
Mequon, WI 53092]

Include in your letter of appeal the following information:

- Your name.
- If applicable, the name of the Authorized Person acting on your behalf.
- Your identification number, address, and telephone number. Please include the best time to reach you.
- The decision that you are appealing. Include all the facts and issues related to your appeal, the names of any Dentists involved with your treatment, and medical records, if applicable.
- The resolution you are requesting.

You or your dentist may submit written comments, records and other information when you file an appeal. You may also request, free of charge, copies of all records and other information which were relied on or created by *the Plan* in the process of reviewing a claim or pretreatment review request. If benefits for a claim or pretreatment estimate were denied, reduced or terminated based on the professional judgment of a dentist that the treatment is experimental, investigational or not medically necessary or appropriate, *the Plan* will notify you of the identity of the dentist who initially reviewed the claim or pretreatment review request. Your appeal and all relevant information, including information you submitted, will be re-reviewed by a different dentist prior to deciding your appeal.

A final determination will be made on your appeal. You or your Authorized Person (and your dentist if your dentist filed the appeal for you) will be notified of the final determination as soon as possible taking into account the dental circumstances. If you are appealing a denial, reduction or termination of benefits under a claim, you will be notified not later than 30 days after *the Plan* received the appeal. If you are appealing a pretreatment estimate, you will be notified not later than 15 days after *the Plan* received the appeal. If your appeal is expedited, you will be notified as soon as possible, but not later than 72 hours after *the Plan*

received the appeal. *The Plan* will notify you or your Authorized Person (and your dentist if your dentist filed the appeal for you) of the final determination in writing, or orally followed by a written confirmation if the appeal was expedited.

External Review

If your appeal is denied, the notice will include the specific reason for the denial and the specific Policy provisions on which the denial is based, and you will be entitled to request, free of charge, copies of all records and other information which was relied on or obtained in denying the appeal.

If your appeal is denied, you, your Authorized Person or your Dentist may, within 60 days of receipt of a notice of denial, request an External Review of your appeal by an independent review organization under any of the following circumstances:

1. The reason for the denial is that the services were not medically necessary, and the denied services will cost You more than \$500 if they are not covered; or
2. The reason for the denial is that the services were not medically necessary, and your Dentist certifies that Your condition could, in the absence of immediate medical attention, i) place your health or if you are pregnant, the health of your unborn child, in serious jeopardy; or ii) jeopardize your ability to regain maximum function; or
3. The reason for the denial is that the services were experimental or investigational, and your treating Dentist certifies that one of the following situations is applicable: 1) Standard health care services have not been effective in improving the covered individual's condition; 2) Standard health care services are not medically appropriate for the covered individual; or 3) There is no available standard health care service covered by the Plan that is more beneficial than the requested health care service.

You may not request an External Review based upon a determination by *the Plan* that dental services furnished or proposed to be furnished to you are specifically limited or excluded under the Policy.

All requests for External Review must be submitted to [Appeals Department, Ohio DentaTrust Dental Plan, c/o DentaQuest, LLC, 12121 North Corporate Parkway, Mequon, WI 53092]. If your request for External Review is made as set forth above, you must make your request for an External Review in writing, and your Dentist must certify in writing that the denied services will cost more than \$500. If your request for External Review is made under paragraph 2 above, you may make your request on an expedited basis orally or electronically, but you must follow up your request in writing within 5 days of the oral or electronic request. If your request is made under paragraph 3 above and your Dentist determines that the services would be significantly less effective if not promptly begun, you may make your request on an expedited basis orally or electronically, but you must follow up your request in writing within five (5) days of the oral or electronic request.

If you request External Review of a decision of *the Plan* to deny your appeal and your request meets one of the circumstances described above, *the Plan* will assign an independent review organization from a list provided by the Ohio Department of Insurance to review your appeal. You will not be required to pay for the External Review. The independent review organization will review your appeal within the time period required by Ohio law, and will send you and *the Plan* a written notice of their decision.

Complaints to the Department of Insurance

If a complaint or an appeal is not resolved to your satisfaction or if it involves a contractual issue that did not involve a medical judgment or a determination based on medical information (except for emergency services), you have the right to ask the Superintendent of Insurance of Ohio to review your complaint or appeal. The address is 50 W. Town Street,

Third Floor – Suite 300, Columbus, Ohio 43215; telephone (614) 644-2673 or 1-800-686-1526.

25. CONVERSION

Under the circumstances set forth below, covered individuals have the option to convert to another dental plan offered by the Plan.

Conversion shall be available without evidence of insurability. Upon receipt of a written application and upon payment of at least the first quarterly premium not later than thirty-one (31) days after the termination of coverage under this Policy, the Plan shall issue a converted policy.

The option for conversion is available to the following individuals:

1. Upon the death of the Subscriber, to the surviving spouse with respect to such of the spouse and dependents as are then covered by the Policy;
2. To a child solely with respect to the child upon attaining the limiting age of coverage under the Policy while covered as a dependent thereunder;
3. Upon the divorce, dissolution, or annulment of the marriage of the Subscriber, to the divorced spouse, or former spouse in the event of annulment, of such Subscriber, or upon the legal separation of the spouse from such Subscriber, to the spouse.

Part V Filing a Claim

1. EXPLANATION OF BENEFITS (EOB)

Each time we process a claim for you under this Policy, a written notice will be sent to you explaining your benefits for that claim. This notice will tell you how we paid the claim or the reasons it was denied. The notice is called an Explanation of Benefits or “EOB.”

2. WHO FILES A CLAIM

Contracting Dentists: *Contracting Dentists* will file claims directly to us for the services covered by this *contract*. We will make benefit payments within thirty (30) days to them.

3. TIME LIMIT

All claims for benefits under the *Agreement* for services must be submitted within ninety (90) days of the date that the *covered individual* completes the service unless the claim was initially submitted to another third party payer or state or federal program. If the claim was initially submitted to another third party payer or state or federal program, the claim must be submitted within forty-five (45) days of receiving notice that the first payer denied the claim. Failure to submit the claim within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the claim within the time required, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the *covered individual*, not later than one (1) year from the time the *covered individual* should have submitted the claim.

If benefits are denied because a *Contracting Dentist* fails to submit a claim on time, you will not be responsible for paying the dentist for the portion of the dentist’s charge that would have been a benefit under the dental plan. This applies only if the *covered individual* properly informed the *Contracting Dentist* that he or she was a *covered individual* by presenting his or her dental plan identification card. The *covered individual* will be responsible for his or her patient liability, if any.

4. WHEN YOU FILE A CLAIM

If you file a claim, the following rules apply. Obtain an Attending Dentist’s Statement claim form from *the Plan*. As the Plan does not require a written request for a claims form, the *covered individual* may also call the Customer Service Department at [1-855-343-4263] to request a form. A *covered individual* may request a claims form at any time after services are rendered keeping in mind that completed claims forms must be submitted to the Plan no more than ninety (90) days after services are rendered, except under circumstances set out in Section 3 above.

Within fifteen (15) days of receipt of notice, the Plan will provide the *covered individual* claims forms. If the *covered individual* does not receive a claims form within those fifteen (15) days, the *covered individual* will be deemed to have complied with the Plan's requirements of this *contract* for filing a completed claims form, if within the Time Limit under Section 3, the *covered individual* submits written proof covering the service, the character and the extent of the service for which the claim is made.

If you have any questions, contact our Customer Service department. Our telephone number is listed at the end of this Policy.

5. TIME OF PAYMENT OF CLAIMS

After we receive your completed forms, within a reasonable period of time and generally not later than thirty (30) days after we receive the claim (a) send you a check for your claim to the extent of your benefits under this Policy; or (b) send you a notice in writing of why we are not paying your claim; or (c) send you a notice in writing that the legitimacy of the claim is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary to pay your claim. In certain circumstances, we may extend the thirty (30) day time period for an additional fifteen (15) days, and will notify you that the time period has been extended. If you have any questions, contact our Customer Service Department.

Part VI

Index

This index lists the major benefits and limitations of your Policy. Of course, it does not list everything that is covered in your Policy. To understand fully all benefits and limitations you must read carefully through your Policy.

Agreement.....	6[2]
Benefits	6 [9]
Benefits after Cancellation.....	6 [25]
Calendar-year Deductible	6 [5]
Cancellation Policy	6 [19]
Changing the Contract.....	6 [15]
Complex Dental Services.....	6 [10]
Coordination of Benefits.....	6 [26]
Covered Individual	6 [2]
Deductible	6 [6]
Definitions	6 [5]
Diagnostic and Preventive Services.....	6 [9]
Effective Date	6 [6]
Enrollment Change.....	6 [15]
Family Coverage.....	6 [7]
Filing a Claim	6 [37]
Individual Coverage.....	6 [7]
Introduction.....	6 [4]
Limitations and Exclusions.....	6 [13]
Non-Contracting Dentist Benefits.....	6 [22]
Notices	6[25]
Other Contract Provisions.....	6[21]
Contracting Dentist Benefits	6 [21]
Pre-treatment Estimates	6[21]
Restorative Services and Other Basic Services	6[10]
Subscriber	6[8]
Subscriber's Rights and Responsibilities.....	6[4]
Terminating the Contract	6[19]

