INDIVIDUAL AND
GROUP DENTAL PLANS
Certificate of Coverage

DENCAP
dental plans Est. 1984

DENCAP DENTAL PLANS
45 E. Milwaukee Street
Detroit, Michigan 48202
313.972.1400
888.988.3384
www.dencap.com

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June 2015

CERTIFICATE
General Provisions

This Certificate of Coverage (COC) is issued by DENCAP Dental Plans, Inc. (DENCAP). Each person receiving this COC, having completed an application (app) for dental coverage (Cov) and qualifying for such Cov, is entitled to receive Dental Services as set forth in this COC. **Dental Services become available to the Subscriber (Sub) (and any enrolled Dependents (Dep) of the Sub) upon acceptance of the completed app and issuance of this COC.** Cov continues from the initial Cov date through the last day of the month where all Premiums have been fully paid and the Sub remains an eligible participant. This COC is not the Enrollment App and does not amend, extend or alter the Cov afforded by the App; but is subject to all the terms, exclusions and conditions of the Enrollment App. This COC in whole or parts cannot be assigned.

GUARANTEED RENEW.
Cov is guaranteed renewable. See "Termination of Cov" for conditions where non-renewal or cancellation is allowed.

WELCOME TO YOUR DENCAP DENTAL PLAN!
This COC will assist you in obtaining the maximum benefit from your DENCAP Dental Plan. **Please read this COC thoroughly.** It will answer most of your questions about DENCAP procedures and services.
Your Plan is administrated by DENCAP.
The DENCAP Plan differs from traditional dental insurance in that the Plan coordinates your dental care with dental professionals instead of simply paying claims after dental services have been provided. To achieve good oral health, it is necessary for you to participate.
For the best dental health possible, maintain a daily care program. Utilize routine check-ups rather than waiting for problems to arise. Prevention and early intervention are the best roads to optimal dental health.
If ever you have any questions about the DENCAP Dental Plan, please contact one of our service representatives.

Office: DENCAP Dental Plans, Inc.
45 E. Milwaukee Street
Detroit, MI 48202
Phone: 313-972-1400
www.dencap.com

COVERAGE- Group Dental Plans.
DENCAP has entered into this Group Dental Agreement with the Group wishing to provide dental services for its Employees (Emp). "Group" means a sole proprietor, partnership, corporation, association or other entity. "Emp" are individuals engaged in the normal activities of that business or organization, as its Emp on a permanent, active full time basis (twenty (20) or more hours per week); and whose employment is reasonably expected to be permanent at the time those persons are engaged and the contract is established or; retirees of an employer organization, members of an association, or other designations that qualify to be offered group Cov. New hires for Groups shall become eligible for Cov on the first day of the month following the date of Group Cov notification to DENCAP. When the partner of a Sub is also an employee of said Group, the partner must enroll as a Sub as well. Subs of said Group whose apps have been accepted by DENCAP shall receive dental service Cov as provided under the Enrollment App.

COVERAGE- Individual Dental Plans.
DENCAP has entered into this COC with the Sub. "Subs" are individuals who enter into a contract with DENCAP; or on whose behalf a DENCAP contract is entered into, and has received this COC and to whom this contract is issued. Subs shall become eligible for Cov on the first day of the month following the date Cov notification to DENCAP. Subs whose apps have been accepted by DENCAP shall receive dental service Cov as provided under this COC.

DEPENDENT COVERAGE.
Deps are automatically covered when the Sub elects the "Couple", "Two Persons" or "Family" Cov options and lists the Deps on the enrollment app; subject to the limitations cited in the Group Enrollment App. Cov begins as of the

effective date. If both partners are covered as Members of the same Group, a determination must be made as to which party shall be responsible for Dep Cov.

"**Dep**" means:

1. The spouse or partner of a Sub.
2. Children of the Sub up to 26 years of age.
3. Any child who is totally and permanently disabled regardless of age; proof is required.

Notification of a change in Dep status resulting from a marriage, birth, adoption or attainment of eligibility, must be submitted to DENCAP within 30 days of the occurrence. Cov will become effective the first of the month following receipt of notification. For Groups, after the 30 day period, the Dep will be eligible for Cov at the next enrollment period as determined by the Group effective date.

DENTAL BENEFITS.

DENCAP is your assurance that the dental health needs for you will be met. We encourage you not to delay treatment until a problem arises. Minor dental problems can become serious if left untreated. Your Dental Plan covers routine visits and other diagnostic services; which enable your dentist to diagnose and prescribe proper treatment for your needs.

The complete "Schedule of Benefits" is available by request from your employer or directly from DENCAP. If you have not received this Schedule, contact DENCAP at 313-972-1400. Based upon Group/Sub COC renewal, the Schedule may be modified. Limitations and Exclusions from Cov may be found as part of this COC.

ELIGIBLE SUBSCRIBERS.

You can verify your eligibility by contacting DENCAP Membership Services at 313-972-1400.

IDENTIFICATION CARD.

You will receive a DENCAP Identification (ID) Card. Please present this card when visiting your DENCAP Dental Center. Additional ID may be required by your Center, which reserves the rite to verify your eligibility before treatment.

This card shall remain the property of DENCAP and is not transferable. Upon cancellation of the Sub's eligibility, this card is void.

If this ID card is lost or stolen, please notify DENCAP immediately:

DENCAP Dental Plans, Inc.
45 E. Milwaukee Street
Detroit, Michigan 48202
313-972-1400
info@dencap.com

DENCAP shall issue a new dental ID card within 30 days of notification from the Sub of the lost or stolen ID card.

ACCESS TO DENTAL CARE.

Your selected DENCAP Primary Care Dentist is your "personal dentist". This dentist will see to it that all of your dental needs are satisfied. If you should require specialty dental care, your DENCAP Dentist will arrange with DENCAP to refer you to a Specialist. You will be responsible for the appropriate specialty co-payments.

For Specialty Care treatment, the Sub or Dep is responsible to follow up within 90 days of the Specialty Care referral. In the event the Sub does not follow up with the Specialist, the referral is void. Should a DENCAP Specialist not be available within thirty (30) minutes travel, a Sub may select another Specialist to perform treatment. The same level of Specialty Care for the Plan applies.

Your DENCAP Dental Center will maintain your complete dental records. In addition, the Center will provide convenient hours, routine appointments within (30) days and a twenty-four (24) hour answering service for emergencies.

If you have to cancel an appointment, please let your Dental Center know at least twenty-four (24) hours in advance. You will be assisting office personnel in making your canceled appointment available to someone else. If you fail to cancel the appointment, the Center may bill you for the missed appointment.

As a Sub or Dep of DENCAP, many of your costs have been greatly reduced. We recommend that you make an appointment with your DENCAP Dental Center to ensure that your dentist can correct any current problems and begin a treatment plan for continuous good dental health.

APPOINTMENT FOR SERVICE.
Services will be provided by "appointment only". All reasonable efforts will be made to give appointments within 30 days of request.

EMERGENCIES AND OUT-OF-TOWN COVERAGE.
Your DENCAP Dental Plan provides Cov on a twenty-four (24) hour basis, three hundred sixty-five (365) days a year. Should an emergency arise after regular office hours, your selected DENCAP Center may have a staff member available to receive your call should you need care. This staff member will notify your DENCAP Dentist of the dental emergency. If for any reason you are unable to contact your regular DENCAP Dental Center, phone the DENCAP Emergency Hotline at 313-972-1400.
When you or an enrolled Dep is at least fifty (50) miles away from your DENCAP Center and an emergency arises, you should seek treatment from a dentist in the area. **"Emergency Treatment" is defined as dental services required to alleviate pain which, if not treated immediately, would result in jeopardy to the dental health of the Sub.** DENCAP will reimburse you or your covered Dep for fifty percent (50%) of the amount up to one hundred dollars ($100.00) of only those emergency services which relieve severe pain or discomfort that are covered benefits. A copy of the receipt indicating services and charges must be submitted to DENCAP to receive reimbursement.
FOLLOW-UP TREATMENT FOR ANY EMERGENCY MUST BE OBTAINED FROM YOUR DENCAP DENTAL CENTER.

SUBSCRIBER OBLIGATIONS.
Your DENCAP Dental Plan is designed to deliver quality dental care. To help us accomplish this goal, **DENCAP highlights the following points:**

1. Sub shall complete the DENCAP Dental Plan Enrollment App truthfully.
2. Sub shall be truthful in statements made to DENCAP.
3. Select a DENCAP Dental Center located near you. This will ensure that your routine visits and emergency needs may be handled conveniently.
4. Make your appointments in advance. "Squeezing you in" for an appointment or "walk-ins" only result in unnecessary delays for everyone.
5. When a co-payment is required for dental service, the amount should be paid at the time of your visit unless prior arrangements have been made with your Dental Center.
6. If you receive out-of-town emergency care, notify your DENCAP Dentist so that follow-up treatment can be arranged.
7. Consultation with a Specialist outside of the Provider Network, to whom you have not been referred by DENCAP, is not a covered benefit. Any fees or costs incurred are your responsibility.
8. You must notify your DENCAP Center if you or your Deps are eligible to receive dental benefits through another plan.
9. Sub shall notify DENCAP of any changes in Sub's address within 30 days of occurrence.
10. Sub shall notify DENCAP of any changes in the status of Dep Cov.
11. Sub shall cooperate with DENCAP in enforcing subrogation rights (collection from another insurance company) as a condition for receiving benefits and services under the Enrollment App. The Sub will make a good faith effort to assist recovery from the liable carrier.
12. DENCAP can only keep you and your enrolled Deps in good dental health with your assistance. It is up to you to plan regular check-ups, practice good dental hygiene and to contact your dentist at the first sign of a dental problem.

RECORDS.
DENCAP shall keep all information and dental records pertaining to Subs confidential. Information and records shall be maintained to the extent and degree professionally required.
Records pertaining to a Sub or enrolled Dep shall be made available; when reasonably requested, for inspection and review by the Sub and those persons authorized by the Sub to inspect and review such records. Copies shall be made available for inspection and review to the extent legally and professionally ethical.
DENCAP protects patient health information according to HIPAA legislation. A copy of the DENCAP Dental Plans Notice of Privacy Practices is available by contacting the DENCAP administrative offices: 313-972-1400.

THEFT OF MEMBERSHIP IDENTIFICATION.

DENCAP is in compliance with all HIPAA legislation and regulation; and treats all Sub information as Confidential. Should a Sub deem that their information has been compromised then the Sub should follow the procedure outlined in "SUB SATISFACTION PROGRAM and GRIEVANCE PROCESS."

PAYMENT OF GROUP PREMIUMS (Group Dental Plans).
Under the Agreement between DENCAP and the Group, the Group shall pay Sub Premiums on behalf of the Sub; the Premiums are payable monthly in advance. (Any arrangement between the Group and the Sub under which the Sub is to reimburse the Group for any portion of the premiums is entirely between the Group and the Sub; DENCAP looks solely to the Group for payment of Premiums.) A grace period of 14 days shall be allowed for the payment of Sub Premiums during which the Agreement will remain in effect. Should the Group fail to pay any installment, the Agreement shall terminate as of the end of the grace period without the necessity of notice to either the Group or the Sub. DENCAP shall accept payment of Premiums from the Group after the expiration of said grace period; Cov shall be reinstated as of the date of such acceptance of payment. Upon termination for any reason, the Group shall be liable for all Premiums then due; including charges for any time the Agreement remains in force during said grace period.

PAYMENT OF SUBSCIBER PREMIUMS (Individual Dental Plans).
Under this COC between DENCAP and the Sub, the Sub shall pay Sub Premiums; the Premiums are payable monthly in advance and are due the last day of the preceding month. A grace period of 10 days shall be allowed for the payment of Sub Premiums; during which the COC will remain in effect. Should the Sub fail to pay any installment, the Cov shall terminate as of the last day of the month that premiums were paid; without the necessity of notice to the Sub. DENCAP shall accept payment of Sub Premiums from the Sub after the expiration of said grace period; Cov shall be reinstated as of the date of such acceptance of payment for the Cov months paid. Upon termination for any reason, the Sub shall be liable for all Sub Premiums then due, including reinstatement charges.

LIMITATIONS AND EXCLUSIONS.

LIMITATIONS: Benefits provided under the DENCAP Dental Plan are subject to the following limitations:

1. **Preventative.** Initial exam limited to once per year. Periodic and limited examinations; including those by a specialist, are limited to twice per year. Prophylaxis (teeth cleaning); including periodontal cleanings, are limited to three per year (pediatric) and two per year (adult). Two additional cleanings may be allowed per year for patients that are pregnant, diabetic, have a suppressed immune system or have extensive periodontal history as determined by a dental professional. All images limited to twice per year.
2. **Prosthodontics.** A prosthodontic appliance, crown, inlay or bridge, placed solely for the purpose of replacing an existing serviceable appliance will not be provided. When a prosthodontic appliance, crown, inlay or bridge is less than three years old, no replacement for said appliance, crown, inlay or bridge would be provided under the program; unless such placement is needed because of the extraction of natural teeth during the same period of continuous Cov.
3. **Restorative.** If a tooth can be restored with amalgam, composite or plastic, these will be the materials used to restore the tooth. The judgment will be solely that of the Dentist providing the service.
4. **Mouth Rehabilitation.** If a patient and the Dentist select a course of mouth rehabilitation; the obligation of the DENCAP Dental Plan will be to cover only those benefits appropriate to eliminate oral disease and replace missing teeth as needed (does not include implants). The balance of the treatment, including costs to increase vertical dimension or restore the occlusion; will remain the financial responsibility of the patient.
5. **Orthodontics.** Care for braces will be provided when in the opinion of the Orthodontic Consultant; a satisfactory result can be achieved. Treatment is limited to class I and II cases and to 24 months. Orthodontic records and case studies are not maximum benefit. Cross bite in permanent dentition (teeth) will only be treated when; in the opinion of the Orthodontist, the other conditions are present which would indicate that orthodontic treatment is necessary.
6. **Interceptive Orthodontics.** Discounts for Interceptive Orthodontics may be available at specific DENCAP provider locations.
7. **Temporal Mandibular Joint Disorder/Dysfunction.** This is not a covered service.
8. **Periodontics.** Services or supplies related to periodontal splinting or crown lengthening are not covered.

9. **Pedodontics.** Specialty services are provided for Deps under the age of six; with an approved referral by a DENCAP Network Provider. Exceptions can be made on a case-by-case basis for emergency dental treatment and/or treatment for special needs or disabled Dep.

EXCLUSIONS:
The following treatments are not covered under the DENCAP Dental Plan:

1. **General Exclusions.**
   a. Dental services not appearing on the "Schedule of Benefits and Co-Payments".
   b. Dental treatment for cosmetic purposes only. Cosmetic dentistry includes those procedures that improve the appearance of the dental structures such as dental implants, transplants or grafts
   c. Services needed solely in connection with non-covered treatment.
   d. Retreatment of root canal therapy; within five years of original root canal, if final restoration has not been completed.
   e. Dental treatment performed by any dentist not under contract by DENCAP.
   f. Dental treatment performed in a hospital and/or any related hospital fee.
   g. Dental treatment performed due to systemic etiology such as ongoing treatment of mal-formed jaw/bone structure and dental services as a result of continuous repairs to such treatment.
   h. Treatment of cleft lip, cleft palate, anodontia, mandibular prognathism and/or other maxillofacial or orthognathic deformities.
   i. The replacement of lost, stolen or missing prosthetic appliance(s); and those for replacement due to abuse, misuse or neglect (i.e., orthodontic retainer, occlusal guard).
   j. Space maintainers, except when needed to preserve space resulting from premature loss of deciduous teeth.
   k. Tooth preparation, temporary crowns, bases, impressions, anesthesia or other services which are part of the complete dental procedure. These services are considered components of; and included in the fee for, the complete procedure. Separate fees may not be charged by participating dentists.
   l. Charges for duplication of x-rays.
   m. Additional charges that apply for lab fees; and/or precious metals for all procedures involving crowns, bridges, prosthodontics, space maintainers, appliances and any repairs to such items.
   n. Cases which in the professional judgment of the attending Provider or the DENCAP Dental Director; a satisfactory result cannot be obtained.
   o. Treatment for any condition for which benefits of any nature are recovered or found to be recoverable; whether by adjudication or settlement under any Workers Compensation or Occupational Disease Law, even though the Sub fails to claim the right to such benefits, provided that his/her exclusion shall only apply to the extent that such benefits are payable through such other plans.
   p. Care or treatment obtained from or for which payment is made by any Federal, State, County, Municipal or other government agency; including any foreign government.
   q. The cost of treatment not completed in a reasonable time frame after diagnosis due to delays by a Sub.
   r. Any treatment for or in connection with services, procedures, drugs or other supplies that are determined by DENCAP to be experimental or still under clinical investigation by health professionals.

CLAIMS PROCEDURES.
All clean claims received are payable within 45 days of receipt of the final documentation ensuring a clean claim and are payable to the dental office.

PREAUTHORIZATION PROCEDURES.
Preauthorizations are required for periodontal procedures and specialty care requiring a referral. All Preauthorizations are responded to within 14 days of receipt.

UTILIZATION REVIEW AND ADVERSE BENEFIT DETERMINATION PROCEDURES.
All claims are analyzed for utilization compliance and adverse benefit determination per the frequencies and policies outlined in Limitations and Exclusions; as well as any listed on the Schedule of Benefits and fixed Co-Pays. To obtain the clinical review criteria used to determine dental necessity in particular situations, submit your request to: DENCAP Dental Plans, Attn: Claims Department, 45 East Milwaukee, Detroit, MI 48202. All information will be provided within 30 days of receipt of such request.

COORDINATION OF BENEFITS.
If a Sub is eligible for dental benefits under any other health care or insurance plan(s), either the benefits provided by DENCAP shall be reduced or DENCAP shall deduct from such plan. The cost of the benefits which have been provided or paid for by DENCAP; which are provided or paid by such other plan or insurance, so that during the calendar year, up to but not more than one hundred percent (100%) of the Sub's dental expenses will be paid by all such plans. To determine the benefits available under this provision, the following rules apply:

1. For those plans that do not have applicable coordination of benefits clauses:
   Where the Coordination of Benefits occurs between DENCAP and a carrier outside of Michigan, if the other state has no birthday rule; then the rules of the other state determine the primary/secondary order of Cov.
2. For those plans that have applicable coordination of benefits clauses:
   a. The benefits of the plan which cover the Member as a Sub will be determined before the benefits of the plan which cover the Member as a Dep.
   b. Except as otherwise provided in section (c); if two (2) COCs cover a Sub as a Dep, the benefits of the COC of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the COC of the person whose birthday anniversary occurs later in the year. If the birthdays are identical, the benefits of a COC which has covered the Sub as a Dep for the longer period of time shall be determined before the COC which has the shorter period of time.
   c. Claims for children of separated or divorced spouses which involved covered expenses will be administered with the following rules:
      i. Benefits for a Dep child of divorced or separated parents will be determined first by the plan covering the child as a Dep of the parent with custody, prior to the plan of the parent without custody.
      ii. Benefits of the plan covering the Dep child of a married parent will be determined first by the plan covering the child as a Dep of the parent with custody; second, as a Dep of a stepparent and finally, will be determined by the plan covering the child as a Dep of the natural parent without custody.
      iii. If a court decree otherwise establishes financial responsibility for dental expenses for Dep children, rules i. and ii. above will not apply. Benefits of the plan covering the child as Dep of the parent with such responsibility will be determined prior to any other plan that covers the child.
3. If the above paragraphs do not establish an order of benefit determination; the benefits of a policy that has covered the person for the longer period of time shall be determined before the benefits of a policy which has covered the person for the shorter period of time. Subject to the following:
   a. The benefits of a policy covering the person as a laid-off or retired employee or as a Dep of a laid-off or retired employee shall be determined after the benefits of policy covering the person or Dep other than a laid-off or a retired person.
   b. "Paragraph a." shall not apply if either policy is lawfully issued in another state; and does not have a provision regarding laid-off or retired emp. As a result, each policy determines its benefits after the other.

DENCAP may release or obtain any information and make or recover any payments it considers necessary to administer this Coordination of Benefits (COB) provision.

TERMINATION OF COVERAGE.
Cov of a Sub shall cease if at any time:

(a) Fraud.
(b) Intentional misrepresentation of material fact.
(c) The participant is no longer eligible for Cov through the Exchange.
(d) A rescission for a non-prohibited reason is made.
(e) DENCAP exits the market/Exchange.
(f) The participant changes products.
(g) The participant moves outside the service area.
(h) Participation by the Sub within the Group terminates (Group Dental Plans)
(i) If the Group fails to remit Group Premiums (Group Dental Plans)
(j) If, after the designated term period of Cov for Subs of the Group (Group Dental Plans)
(k) The Group Enrollment App is terminated either by DENCAP or the Group (Group Dental Plans)
(l) If Sub fails to remit Premiums (Individual Dental Plans)

Termination of Cov requires 30 days prior notice given by the party that is terminating Cov (either DENCAP or Sub/Group). The notice must include the reason for termination. Participants may terminate Cov upon no greater than 14 days notice to DENCAP or to the Exchange.

For Group Dental Plans, upon request by the Sub and verification by DENCAP that the Sub is eligible, the Sub may continue treatment pursuant to the rights of the Sub as indicated pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, Title X (COBRA), if COBRA Cov is offered by the employer.

FAILURE TO REPORT TERMINATION.
Failure of the Group Administrator (Admin) to report Sub terminations for the month in which they occur will result in the Sub being responsible for the full dollar amount of the dental service(s) provided to the Sub and/or enrolled Dep. If the Group Admin terminates Cov prior to the 10th day of the month, then the Group will not be held responsible for the Monthly Premiums for that month. If the Group Admin terminates Cov after the 10th of the month, then the Group will be held responsible for the premium for that month. All terminations must be submitted to DENCAP in writing via e-mail, fax or mail.
For the Individual Dental Plans, Sub must notify DENCAP Dental Plans of any changes in Cov for Deps.

SUBSCRIBER SATISFACTION PROGRAM and GRIEVANCE PROCESS.
A Quality Assurance Committee has been established to monitor dental care. Committee Members analyze results to determine the quality of care.
To further ensure the care Subs receive is one of quality, DENCAP has established Internal and External Grievance Procedures.

Internal Informal Grievance Process.
If a Sub is not satisfied with the care received from their Provider; the Sub is urged to first discuss the problem with the dentist.
If the problem is not resolved, complaints can be addressed to DENCAP by telephone: 313.972.1400, fax: 313.972.4662 or email: fberge@dencap.com.
If DENCAP is not able to resolve the matter, a Sub is encouraged to follow the Internal Formal Grievance Process below so that DENCAP can address the concerns in a prompt manner.

Internal Formal Grievance Process.
If the situation is not resolved to their satisfaction through this contact with DENCAP, a Sub is asked to express their concerns in writing. Subs are to send notice to DENCAP:

DENCAP Dental Plans, Inc.
Attn: Member Services
45 E. Milwaukee Street
Detroit, MI 48202

Subs are instructed to include the information below with their comments:
A-Sub's name.
B-Sub's ID Number.
C-Brief explanation of the situation they wish to resolve.
D-Suggestions as how the situation could be resolved to their satisfaction.

A DENCAP Representative will promptly address their concerns. The DENCAP Dental Director or designee will fully investigate the matter. A Sub shall receive timely notification about the progress of an investigation.
A Sub may authorize in writing any person, including, but not limited to, a dentist to act on their behalf at any stage in a grievance proceeding.
If the Sub is not satisfied with the determination, the Sub has the right to appear before a manager to present the grievance.
He/She has sixty (60) days after the date of the notification of the adverse determination to request a review and appear before a manager.

Within seven (7) business days after receipt of the request, DENCAP will notify the Sub of the time and place of the manager meeting and of the Sub's right to be present.
The Sub shall be provided written notification of the final decision within seven (7) business days following the meeting.
A final determination will be made in writing by DENCAP not later than thirty-five (35) days after the Sub submits a formal grievance in writing. The timing for the thirty-five (35) days after a formal grievance may be suspended for a period of sixty (60) days by the Sub; and for a period of time that shall not exceed ten (10) business days if DENCAP has not received requested information from a health care facility or health professional. The only way this time frame can be extended is if the Sub requests an extension.
Subs have a right to an External Review if DENCAP does not issue a written decision within the time frames established by law.
When an adverse determination is made, written notification of the reasons for the adverse determination will be provided to the Sub; along with written notices as required under the Patient's Right to Independent Review Act. DENCAP is required to provide a form to request such an External Review.

LEGAL ACTIONS: No action of law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

External Review Process.
The Sub has the right to a review of the matter by the Director of the Department of Insurance and Financial Services (DIFS) or their designee or by an Independent Review Organization under the Patient's Right to Independent Review Act.
Subs are informed of their right to file for an External Review of an adverse determination with the State Director of DIFS, after having exhausted the DENCAP Internal Formal Grievance Process.
This filing must occur not later than sixty (60) days after the date of receipt of a notice from DENCAP of an adverse determination.
Included with the information provided by DENCAP is the address and phone number for filing a grievance at the State level:

Department of Insurance and Financial Services
Office of General Counsel / Health Care Appeals Section
PO Box 30220
Lansing, Michigan 48909-7720
Phone: 1.877.999.6442

A Sub has the right to submit additional information along with the forms used to process an External Review.
Forms needed to start the External Grievance Procedure are also available through the website of www.michigan.gov/difs or through their toll free number of 1.877.999.6442.

Expedient Resolution.
If the nature of the Grievance requires a more expedient resolution, telephone or email the Dental Director immediately. This applies when a dentist, orally or in writing, substantiates that the time frame for a grievance under consideration would jeopardize the life of the Sub or would jeopardize the Sub's ability to regain maximum function.

Telephone: 888-988-3384
Email: fberge@dencap.com

Be sure to include items A-D above and your telephone number and/or email address.
A determination will be made by DENCAP not later than seventy-two (72) hours after receipt of an expedited grievance. Within ten (10) days after receipt of a determination, the Sub may request a determination of the matter by the Dental Director or their designee or by an Independent Review Organization under the Patient's Right to Independent Review Act.

Grievances – Filing Time Period.
A Sub has 180 days from the date of discovery to file a Grievance, unless the Sub can show conclusively that circumstances required a longer period of time prior to filing the Grievance.

ADDENDUM

I. This COC, including the "Schedule of Benefits" and any endorsements attached hereto, constitutes the entire Agreement between the Sub and DENCAP; and the detailed terms and conditions of the Enrollment App shall govern with respect to all dental services referred to herein. No statement by the Sub in the app for the Sub COC shall void this COC or be used in any legal proceeding hereunder unless such app or an exact copy thereof, is attached with this COC.

II. No agent of DENCAP has authority to change this COC or to waive any of its provisions. No change shall be valid unless approved by an officer of DENCAP and unless such approval be endorsed or attached to the COC and approved by DIFS of the State of Michigan.

III. The Provider and Provider's contracted dentists shall be solely responsible for all dental service advice and service performed or prescribed by them. Neither DENCAP, nor any of its agents shall be liable for injuries, damages or expenses resulting from negligence, malfeasance, nonfeasance or malpractice on the part of any officer or employee or agent of the Provider and Provider's contracted dentists or on the part of any person, organization or entity rendering services to a Sub.

IV. Services hereunder are personal to the Sub and are not assignable.

V. All dental services to be rendered to the Sub and Dep(s) hereunder, shall be performed at the DENCAP Dental Center designated in the Sub's app unless specifically authorized by DENCAP or the Dental Center. The Sub shall be entitled to select a dentist from those in the designated Dental Center to perform the services to be rendered hereunder. Further, the Sub shall have the right to transfer to another DENCAP Dental Center by giving at least 30 days prior notice to DENCAP by the 10th of the month prior to the month the change becomes effective.

VI. Indemnity in the form of cash will not be paid to any Sub.

VII. Subs, upon request, are entitled to information regarding the professional credentials of providers and the financial arrangements between DENCAP and its providers.

VIII. Any notice required or permitted to be given by DENCAP hereunder shall be deemed to have been given if in writing and personally delivered, or if in writing and deposited in the United State Mail with postage prepaid, addressed to the Sub at the last address of record at the principal office of DENCAP Dental Plans, Inc. Such notice shall be deemed to have been given when so personally delivered or mailed.

IX. The catch line and captions in no way shall be considered to be part of this COC, but are inserted only for the purpose of convenience.

X. This COC may not be amended without providing the Group or Subs affected thereby with a clear written statement setting forth the extent and nature of the proposed changes. Amendments may be communicated to the Subscribership through periodic DENCAP releases or newsletters.

XI. Conditions of eligibility are specified in this COC under "COVERAGE".

XII. The effective date is specified in the Enrollment App.

XIII. Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

XIV. The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

XV. This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

XVI. The grace period for premium receipt for insureds who receive premium tax credits is 3 months.

XVII. No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

XVIII. Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of

the insured or the beneficiary to the insurer at DENCAP Dental Plans, 45 East Milwaukee, Detroit, MI 48202 Attn: Claim Department or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

XIX. Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

XX. Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 1 year from the time proof is otherwise required.

XXI. After 3 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the app for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 3-year period.

XXII. No claim for loss incurred or disability (as defined in the policy) commencing after 3 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from Cov by name or specific description effective on the date of loss had existed prior to the effective date of Cov of this policy.

XXIII. This COC is made and shall be interpreted under the laws of the State of Michigan. The following regulations do not apply to your plan because of the following:

500.3407: We do not consider genetic testing for issuing, renewing or continuing policy or COC; we do not discriminate against genetic medical conditions.

500.3412,3413,3414,3416,3418: All of these codes apply to claims. DENCAP is a DHMO model and does not process claims. The member obligation is limited to the appropriate Schedule of Benefits effective at the time of service.

XXIV. DENCAP may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this COC.

DEFINITION OF TERMS.

Adverse determination: A determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

Class I (Orthodontics): Neutrocclusion - The molar relationship of the occlusion is normal or as described for the maxillary first molar, but the other teeth have problems like spacing, crowding, over or under eruption, etc.

Class II (Orthodontics): Distocclusion (retrognathism, overjet) - The upper molars are placed not in the mesiobuccal groove but anteriorly to it. Usually the mesiobuccal cusp rests in between the first mandibular molars and second premolars.

Clean Claim: A claim that is properly filled out, qualifies for payment, and has all supporting documentation to enable adjudication.

Grievance: A complaint on behalf of a covered Member submitted by a covered Sub or Dep concerning any of the following: (i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (ii) Benefits or claims payment, handling, or reimbursement for health care services; (iii) Matters pertaining to the contractual relationship between a covered Member and the Cov company or health maintenance organization.

HIPAA: Health Insurance Portability and Accountability Act**.**

Provider: The dentist, the employer of the dentist, and Emp. who assist in providing dental services to the Sub.

Schedule of Benefits: Covered dental benefits provided with this COC.

Systemic Etiology: A malady that requires ongoing treatment.

Sub or Participant: Individuals who hold policy or, in cases of groups, individuals engaged in the normal activities of that business or organization, or Subs that form a group such as retirees of an employer organization, members of an association, or designations that qualify to be offered group Cov.

Pediatric: Up to and including the month the patient turns 19.

Premium: Monthly amount due to DENCAP to maintain Cov.