DENCAP CLASSIC DENTAL PLAN

CERTIFICATE OF COVERAGE

Offered and Underwritten by

DENCAP Dental Plans
45 E. Milwaukee Street
Detroit, Michigan 48202
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888.988.3384
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DENCAP Dental Plans

DENTAL CERTIFICATE OF COVERAGE

This Certificate of Coverage ("Certificate") sets forth your rights and obligations as a Covered Person. It is important that you READ YOUR CERTIFICATE CAREFULLY and familiarize yourself with its terms and conditions.

The Policy may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost a Subscriber must pay can be obtained from the Enrolling Group.

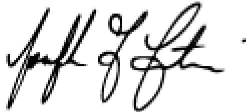
DENCAP Dental Plans, Inc. (DENCAP) agrees with the Enrolling Group to provide Coverage for Dental Services to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. The Policy is issued on the basis of the Enrolling Group's application and payment of the required Policy Charges. The Enrolling Group's application is made a part of the Policy.

DENCAP shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. DENCAP shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's benefit plan.

The Policy shall take effect on the date specified and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of the Policy as provided. All Coverage under the Policy shall begin at 12:01 a.m. and end at 12:00 midnight at the Enrolling Group's address.

The Policy is delivered in and governed by the laws of the State of Michigan.

DENCAP Dental Plans, Inc.



Joseph T. Lentine, President and CEO

CERTIFICATE

Introduction

You and any of your Enrolled Dependents, for whom the required Premiums have been paid, are eligible for Coverage under the Policy. The Policy can be referred to as “Certificate” or "Policy" and is designated on the identification ("ID") card.

Coverage is subject to the terms, conditions, exclusions, and limitations of the Policy. As a Certificate, this document describes the provisions of Coverage under the Policy but does not constitute the Policy. You may examine the entire Policy at the office of the Enrolling Group during regular business hours.

For Dental Services rendered after the effective date of the Policy, this Certificate replaces and supersedes any Certificate, which may have been previously issued to you by DENCAP. Any subsequent Certificates issued to you by DENCAP will in turn supersede this Certificate.

How To Use This Certificate

This Certificate should be read and re-read in its entirety. Many of the provisions of this Certificate are interrelated; therefore, reading just one (1) or two (2) provisions may not give you an accurate impression of your Coverage.

Your Certificate may be modified by the attachment of Riders and/or Amendments. Please read the provision described in these documents to determine the way in which provisions in this Certificate may have been changed.

Many words used in this Certificate have special meanings. These words will appear capitalized and are defined for you in the Section entitled Definitions. By reviewing these definitions, you will have a clearer understanding of your Certificate.

From time to time, the Policy may be amended. When that happens, a new Certificate or Amendment pages for this Certificate will be sent to you. Your Certificate should be kept in a safe place for your future reference.

Dental Services Covered Under the Policy

Only Necessary Dental Services are Covered under the Policy. The fact that a Dentist has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease does not mean that the procedure or treatment is Covered under the Policy.

DENCAP reserves the right to change, interpret, modify, withdraw or add benefits or terminate the Policy, in its sole discretion, as permitted by law, without the approval of Covered Persons. No person or entity has any authority to make any oral changes or amendments to the Policy.

DENCAP may, in certain circumstances for purposes of overall cost savings or efficiency and in its sole discretion, provide Coverage for services, which would otherwise not be Covered. The fact that DENCAP does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

DENCAP may, in its sole discretion, arrange for various persons or entities to provide administrative services in regard to the Policy, including claims processing and utilization management services. The identity of the service providers and the nature of the services provided may be changed from time to time in DENCAP's sole discretion and without prior notice to or approval by Covered Persons. You must cooperate with those persons or entities in the performance of their responsibilities.

Similarly, DENCAP may, from time to time, require additional information from you to verify your eligibility or your right to receive Coverage for services under the Policy. You are obligated to provide this information. Failure to provide required information could result in Coverage being delayed or denied.

Important Information Regarding Medicare

Coverage under the Policy is not intended to supplement any coverage provided by Medicare, but in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled for Coverage under the Policy. If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare, you must enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll, and if DENCAP is the secondary payer as described in the Section entitled Coordination of Benefits of this Certificate, DENCAP will pay benefits under the Policy as if you were covered under both Medicare Part A and Part B and you will incur a larger out of pocket cost for Dental Services.

If, in addition to being enrolled for Coverage under the Policy, you are enrolled in a Medicare+Choice (Medicare Part C) plan, you must follow all rules of that plan that require you to seek services from that plan's participating providers. When DENCAP is the secondary payer, we will pay any benefits available to you under the Policy as if you had followed all rules of the Medicare+Choice plan. If DENCAP is the secondary plan and you don't follow the rules of the Medicare+Choice plan, you will incur a larger out of pocket cost for Dental Services.

Identification ("ID") Card

Please present your ID card at the Dental Office of your choosing. This allows the Dental Office to contact DENCAP to inquire about your benefits. If you do not have your card at the time of service, you may have the Dental Office contact us at (313) 972-1400 for your benefit information.

Contact DENCAP

Throughout this Certificate you will find statements that encourage you to contact DENCAP for further information. Whenever you have a question or concern regarding Dental Services or any required procedure, please contact DENCAP (313) 972-1400 or you can find the telephone number stated on your ID card.

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SECTION 1 - DEFINITIONS

This Section defines the terms used throughout this Certificate and is not intended to describe Covered or uncovered services.

"Active at Work" or **"Actively at Work"** - at your usual place of business doing all the substantial and material duties of your regular employment or occupation.

"ADA" – abbreviation for the American Dental Association.

"Amendment" - any attached description of additional or alternative provisions to the Policy. Amendments are effective only when signed by DENCAP. Amendments are subject to all conditions, limitations and exclusions of the Policy except for those, which are specifically amended.

"Annual Deductible" - the amount a Covered Person must pay for Dental Services in a calendar year before DENCAP will begin paying for Benefits in that calendar year.

"Annual Maximum Benefit" - the maximum amount paid for Exhibit I (Schedule of Covered Dental Services) during a calendar year for a Covered Person under the Policy or any Policy, issued by DENCAP to the Enrolling Group, that replaces the Policy. The Annual Maximum Benefit is stated in Exhibit III (Plan Benefit Summary).

"Certificate" – the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Enrolling Group.

"Congenital Anomaly" - a physical developmental defect that is present at birth and identified within the first twelve (12) months from birth.

"Copayment" - the charge, in addition to the Premium, which you are required to pay for certain Dental Services provided under the Policy. A Copayment may either be a defined dollar amount or a percentage of Eligible Expenses. You are responsible for the payment of any Copayment directly to the provider of the Dental Service at the time of service or when billed by the provider.

"Coverage" or **"Covered"** - the entitlement by a Covered Person to reimbursement for expenses incurred for Dental Services covered under the Policy, subject to the terms, conditions, limitations and exclusions of the Policy. Dental Services must be provided: (1) when the Policy is in effect; and (2) prior to the date that any of the individual termination conditions as stated in the Section entitled Termination of Coverage occur; and (3) only when the recipient is a Covered Person and meets all eligibility requirements specified in the Policy.

"Coverage Plan" – is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

"Covered Person" - either the Subscriber or an Enrolled Dependent while Coverage of such person under the Policy is in effect. References to "you" and "your" throughout this Certificate are references to a Covered Person.

"CDT" – abbreviation for Current Dental Terminology.

"Dental Office" – a space for either a single dentist's office or a collection of such offices. It may include full dental care or simple oral hygiene and dental triage.

"Dental Service" or "Dental Procedures" - dental care or treatment provided by a Dentist to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by DENCAP as a generally accepted form of care or treatment according to prevailing standards of dental practice.

"Dentist" - any dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render dental services, perform dental surgery or administer anesthetics for dental surgery.

"Dependent" - (1) the Subscriber's legal spouse or (2) an unmarried dependent child of the Subscriber or the Subscriber's spouse (including a natural child, stepchild, a legally adopted child, a child placed for adoption or any other child related to the Subscriber regardless of whether the child was born out of wedlock or claimed as a dependent on the Employee's federal tax return). The term "child" also includes a grandchild of either the Subscriber or the Subscriber's spouse when legal guardianship has been awarded to the Subscriber or the Subscriber's spouse. The principal place of residence of the legal spouse or dependent child must be with the Subscriber unless DENCAP approves other arrangements or except as ordered and described below. The definition of "Dependent" is subject to the following conditions and limitations:

A. The term "Dependent" shall not include any unmarried dependent child 19 years of age or older, except as stated in the next paragraph, or as stated in the Sub-section of the Termination of Coverage Section entitled "Extended Coverage for Handicapped Children":

B. The term "Dependent" shall include an unmarried dependent child who is 19 years of age or older, but less than 26 years of age if evidence satisfactory to DENCAP of the following conditions is furnished upon request:

   1. the child is not regularly employed on a full-time basis; and
   2. the child is a Full-time Student; and
   3. the child is primarily dependent upon the Subscriber for support and maintenance.

The Subscriber agrees to reimburse DENCAP for any Dental Services provided to the child at a time when the child did not satisfy these conditions.

The term "Dependent" also includes a child for whom dental care coverage is required through a "Qualified Medical Child Support Order" or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

The term "Dependent" does not include anyone who is also enrolled as a Subscriber, nor can anyone be a "Dependent" of more than one (1) Subscriber.

"Eligible Expenses" - Eligible Expenses are calculated by DENCAP based on available data resources of competitive fees in that geographic area.

Eligible Expenses must not exceed the fees that the provider would charge any similarly situated payor for the same services. In the event that a provider routinely waives Copayments and/or the Annual Deductible for benefits, Dental Services for which the Copayments and/or the Annual Deductible are waived are not considered to be Eligible Expenses.

Eligible Expenses are determined solely in accordance with DENCAP's reimbursement policy guidelines. DENCAP's reimbursement policy guidelines are developed by DENCAP, in its discretion, following evaluation and validation of all provider billings in accordance with one (1) or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association);
- As reported by generally recognized professionals or publications, such as the current ADA CDT Dental Procedure Codes book
- As utilized for Medicare;
- As determined by medical or dental staff and outside medical or dental consultants;
- Pursuant to other appropriate source or determination accepted by DENCAP.

"Eligible Person" - (1) an employee of the Enrolling Group; or (2) other person who meets the eligibility requirements specified in both the application and the Policy.

"Emergency" - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

"Enrolled Dependent" - a Dependent who is properly enrolled for Coverage under the Policy.

"Enrolling Group" - the employer or other defined or otherwise legally constituted group to whom the Policy is issued.

"Experimental, Investigational or Unproven Services" - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time DENCAP makes a determination regarding coverage in a particular case, is determined to be:

A. Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

B. Subject to review and approval by any institutional review board for the proposed use; or

C. The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or

D. Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

"Full-time Student" - a person who is enrolled in and attending, full-time, a recognized course of study or training at:

A. An accredited high school;

B. An accredited college or university; or

C. A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-time Student status is determined in accordance with the standards set forth by the educational institution. A person ceases to be a Full-time Student on the date the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full-time basis.

A person continues to be a Full-time Student during periods of regular vacation established by the institution. If the person does not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end on the date the person was last enrolled and in attendance at the institution on a full-time basis.

Dependent students whose dental coverage is contingent upon attendance at a school shall not be disqualified for coverage if the Dependent takes a leave of absence from school due to illness or injury. Coverage shall be provided for this Dependent at the same rate as that charged for Dependent student status. Coverage shall continue for twelve (12) months from the last day of attendance in school or until the Dependent reaches that age at which coverage would otherwise terminate, whichever period is shorter. This Dependent child must continue to meet all other eligibility requirements for dependent coverage in the Certificate.

"Grievance" - a real or imagined wrong or other cause for complaint or protest, especially unfair treatment.

"HIPAA" - Health Insurance Portability and Accountability Act

"Initial Eligibility Period" - the initial period of time, determined by DENCAP and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

"Medicare" - Parts A, B, and C of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

"Necessary" - dental care services and supplies which are determined by DENCAP to be appropriate, and

A. necessary to meet the basic dental needs of the Covered Person; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service; and

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by DENCAP; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of the Covered Person or his or her Dentist; and

F. demonstrated through prevailing peer-reviewed medical and/or dental literature to be scientifically sound.

The fact that a Dentist has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Certificate. The definition of Necessary used in this Certificate relates only to Coverage and differs from the way in which a Dentist engaged in the practice of dentistry may define necessary.

"Open Enrollment Period" - after the Initial Eligibility Period, a period of time determined by DENCAP and the Enrolling Group, during which Eligible Persons may enroll themselves and Dependents under the Policy.

"Plan Administrator" – one (1) who manages or directs a dental benefit program on behalf of the program's sponsor.

"Policy" - the group Policy, the application of the Enrolling Group, Amendments and Riders which constitute the agreement regarding the benefits, exclusions and other conditions between the Company and the Enrolling Group.

"Policy Charge" - the sum of the Premiums for all Subscribers and Enrolled Dependents Covered under the Policy.

"Premium" - the periodic fee required for each Subscriber and each Enrolled Dependent in accordance with the terms of the Policy.

"Procedure in Progress" - all treatment for Covered Services that results from a recommendation and an exam by a Dentist. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

"Rider" - any attached description of Dental Services Covered under the Policy. Dental Services provided by a Rider may be subject to payment of additional Premiums and additional Copayments. Riders are effective only when signed by DENCAP and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended.

"Subscriber" - an Eligible Person who is properly enrolled for Coverage under the Policy. The Subscriber is the person on whose behalf the Policy is issued to the Enrolling Group.

"Waiting Period" - period of time for which a Covered Person must wait, after the Effective Date of Coverage, before dental services listed in Exhibit I will be Covered.

SECTION 2 - ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

Section 2.1 Enrollment. Eligible Persons may enroll themselves and their Dependents for Coverage under the Policy during the Initial Eligibility Period or during an Open Enrollment Period by submitting a form provided or approved by the Company. In addition, new Eligible Persons and new Dependents may be enrolled as described below. Dependents of an Eligible Person may not be enrolled unless the Eligible Person is also enrolled for Coverage under the Policy.

If you enroll for Coverage under the Policy, you must remain enrolled for a period of twelve (12) months. If you disenroll at the end of any twelve (12) month period, you must wait twelve (12) months until you are again Eligible for Coverage.

If both spouses are eligible Employees of the Enrolling Group, each may enroll as a Subscriber or be covered as an eligible Dependent of the other, but not both. If both parents of an eligible Dependent child are enrolled as a Subscriber, only one (1) parent may enroll the child as a Dependent.

If you fail to enroll yourself or a dependent during the Initial Eligibility Period or during an Open Enrollment Period, you or your dependent must wait until the next Open Enrollment Period.

Section 2.2 Effective Date of Coverage. Coverage for you and any of your Dependents is effective on the date specified in the Policy. In no event is there Coverage for Dental Services rendered or delivered before the effective date of Coverage.

Section 2.3 Coverage for a Newly Eligible Person. Coverage for you and any of your Dependents shall take effect on the date specified in Exhibit III. Coverage is effective only if DENCAP receives any required Premium and a properly completed enrollment form within 31 days of the date you first become eligible. New employees can enroll with DENCAP outside of the enrollment period and then will renew with the Group's effective date.

Section 2.4 Coverage for a Newly Eligible Dependent. Coverage for a new Dependent acquired by reason of birth, legal adoption, placement for adoption, court or administrative order, or marriage shall take effect on the date of the event. Coverage is effective only if DENCAP receives notification of the event within 31 days.

Section 2.5 Special Enrollment Period. An Eligible Person and/or Dependent who did not enroll for Coverage under the Policy during the Initial Eligibility Period or Open Enrollment Period may enroll for Coverage during a special enrollment period. A special enrollment period is available if the following conditions are met: (a) The Eligible Person and/or Dependent had existing dental coverage under another plan at the time of the Initial Eligibility Period or Open Enrollment Period and (b) Coverage under the prior plan was terminated as a result of loss of eligibility (including, without limitation, legal separation, divorce or death), termination of employer contributions, or in the case of COBRA continuation coverage, the coverage was exhausted. A special enrollment period is not available if coverage under the prior plan was terminated for cause or as a result of failure to pay premiums on a timely basis. Coverage under the Policy is effective only if DENCAP receives the properly completed enrollment form within 31 days of the date of coverage under the prior plan terminated.

A special enrollment period is also available for an Eligible Person and for any Dependent whose status as a Dependent is affected by a marriage, birth, placement for adoption or adoption, as required by federal law. In such cases you must submit a properly completed enrollment form within 31 days of the marriage, birth, placement for adoption or adoption.

SECTION 3 - TERMINATION OF COVERAGE

Section 3.1 Conditions for Termination of a Covered Person's Coverage Under the Policy. DENCAP may, at any time, discontinue this benefit plan and/or all similar benefit plans for the reasons specified in the Policy. When your Coverage terminates, you may have continuation as described in the Section entitled Continuation of Coverage or as provided under other applicable federal and/or state law.

Your Coverage, including coverage for Dental Services rendered after the date of termination for dental conditions arising prior to the date of termination, shall automatically terminate on the earliest of the dates specified below.

A. The date the entire Policy is terminated, as specified in the Policy. The Enrolling Group is responsible for notifying you of the termination of the Policy.

B. The date you cease to be eligible as a Subscriber or Enrolled Dependent.

C. The date DENCAP receives written notice from either the Subscriber or the Enrolling Group instructing DENCAP to terminate Coverage of the Subscriber or any Covered Person or the date requested in such notice, if later.

D. The date the Subscriber is retired or pensioned under the Enrolling Group's Plan, unless a specific Coverage classification is specified for retired or pensioned persons in the Enrolling Group's application and the Subscriber continues to meet any applicable eligibility requirements.

Section 3.2 Extended Coverage for Handicapped Dependent Children. Coverage of an unmarried Enrolled Dependent who is incapable of self-support because they are mentally or physically handicapped will be continued beyond the limiting age specified in the Policy provided that:

A. the Enrolled Dependent becomes so incapacitated prior to attainment of the limiting age; and

B. the Enrolled Dependent is chiefly dependent upon the Subscriber for support and maintenance; and

C. proof of such incapacity and dependence is furnished to DENCAP within 31 days of the date the Subscriber receives a request for such proof from DENCAP; and

D. payment of any required contribution for the Enrolled Dependent is continued.

Coverage will be continued so long as the Enrolled Dependent continues to be so incapacitated and dependent, unless otherwise terminated in accordance with the terms of the Policy. Before granting this extension, DENCAP may reasonably require that the Enrolled Dependent be examined at DENCAP's expense by a Dentist designated by DENCAP. At reasonable intervals, DENCAP may require satisfactory proof of the Enrolled Dependent's continued incapacity and dependency, including medical examinations at DENCAP's expense. Such proof will not be required more often than once a year. Failure to provide such satisfactory proof within 31 days of the request by DENCAP will result in the termination of the Enrolled Dependent's Coverage under the Policy.

SECTION 4 - CONTINUATION OF COVERAGE

Section 4.1 Continuation Coverage. A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law (under COBRA) and as outlined below or in accordance with state law and as outlined in the subsections also shown below.

Continuation Coverage under COBRA shall be available only to Enrolling Groups which are subject to the provisions of COBRA. Covered Persons should contact the Enrolling Group's plan administrator to determine if he or she is entitled to continue Coverage under COBRA.

Continuation Coverage for Covered Persons who selected continuation coverage under a prior plan which was replaced by Coverage under the Policy shall terminate as scheduled under the prior plan or in accordance with the terminating events set forth in Section 4.5 below, whichever is earlier.

In no event shall DENCAP be obligated to provide continuation Coverage to a Covered Person if the Enrolling Group or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation Coverage and notifying DENCAP in a timely manner of the Covered Person's election of continuation Coverage.

DENCAP is not the Enrolling Group's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator.

A Covered Person whose Coverage would otherwise end under the Policy may be entitled to elect continuation Coverage in accordance with federal law, as outlined in Sections 4.2 through 4.4 below.

Section 4.2 Continuation Coverage Under Federal Law. In order to be eligible for continuation coverage under federal law, the Covered Person must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a Qualifying Event:

A. A Subscriber.

B. A Subscriber's Enrolled Dependent, including with respect to the Subscriber's children, a child born to or placed in adoption with a Subscriber during a period of continuation of coverage, or

C. A Subscriber's former spouse.

Section 4.3 Qualifying Events for Continuation Coverage Under Federal Law. If a Qualified Beneficiary's Coverage will ordinarily terminate due to one (1) of the following Qualifying Events, he or she is entitled to continue Coverage. The Qualified Beneficiary is entitled to elect to continue the same Coverage that he or she had at the time of the Qualifying Event.

A. Termination of the Subscriber from employment with the Enrolling Group (for any reason other than gross misconduct) or reduction of hours, or

B. Death of the Subscriber; or

C. Divorce or legal separation of the Subscriber; or

D. Loss of eligibility by an Enrolled Dependent who is a child; or

E. Entitlement of the Subscriber to Medicare benefits; or

F. The Enrolling Group filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Subscriber and his or her Enrolled Dependents. This is also a qualifying event for any retired Subscriber and his or her Enrolled Dependents if there is a substantial elimination of coverage within one (1) year before or after the date the bankruptcy was filed.

Section 4.4 Notification Requirements and Election Period for Continuation Coverage Under Federal Law. The Subscriber or Qualified Beneficiary must notify the Enrolling Group's designated plan administrator within sixty (60) days of his or her divorce, legal separation or an Enrolled Dependent's loss

of eligibility as an Enrolled Dependent If the Subscriber or Qualified Beneficiary fails to notify the designated plan administrator of these events within the 60 day period the Enrolling Group and its plan administrator are not obligated to provide continuation Coverage to the affected Qualified Beneficiary. A Subscriber who is continuing Coverage under Federal Law must notify the Enrolling Group's designated plan administrator within 60 days of the birth or adoption of a child.

Continuation must be elected by the later of 60 days after the Qualifying Event occurs; or 60 days after the Qualified Beneficiary receives notice of the continuation right from the Enrolling Group's designated plan administrator.

A Qualified Beneficiary whose Coverage was terminated due to a qualifying event must pay the initial Premium due to the Enrolling Group's designated plan administrator on or before the 45th day after electing continuation.

Section 4.5 Terminating Events for Continuation Coverage Under Federal Law. Continuation under the Policy will end on the earliest of the following dates:

A. Eighteen (18) months from the date of a Qualifying Event for a Qualified Beneficiary whose Coverage would have otherwise ended due to termination of employment (for reasons other than gross misconduct) or a reduction in hours. A Qualified Beneficiary who is determined to be disabled at the time during the first 60 days of continuation Coverage may extend continuation Coverage to a maximum of 29 months from the date of the Qualifying Event described in Section 4.3. If the Qualified Beneficiary entitled to the additional 11 months of Coverage has non-disabled family members who are also entitled to continuation Coverage, those non-disabled family members are also entitled to the additional 11 months of continuation Coverage.

   A Qualified Beneficiary who is determined to have been disabled within the first 60 days of continuation Coverage for Qualifying Event (A) must provide notice of such disability within 60 days after the determination of the disability, and in no event later than the end of the first 18 months, in order to extend Coverage beyond 18 months. If such notice is provided, the Qualified Beneficiary's Coverage may be extended up to a maximum of 29 months from the date of the Qualifying Event described in Section 4.3. A or until the first month that begins more than 30 days after the date of any final determination that the Qualified Beneficiary is no longer disabled. Each Qualified Beneficiary must provide notice of any final determination that the Qualified Beneficiary is no longer disabled within 30 days of such determination.

B. Thirty-six (36) months from the date of the Qualifying Event for an Enrolled Dependent whose Coverage ended because of the death of the Subscriber, divorce or legal separation of the Subscriber, loss of eligibility by an Enrolled Dependent who is a child, in accordance with qualifying events (B), (C), or (D) described in Section 4.3.

C. For the Enrolled Dependents of a Subscriber who was entitled to Medicare prior to a Qualifying Event that was due to either the termination of employment or work hours being reduced, eighteen months (18) from the date of the Qualifying Event, or if later, 36 months from the date of the Subscriber's Medicare entitlement.

D. The date Coverage terminates under the Policy for failure to make timely payment of the Premium.

E. The date, after electing continuation Coverage, that coverage is obtained under any other group health plan. If such coverage contains a limitation or exclusion with respect to any preexisting condition of the Qualified Beneficiary, continuation shall end on the date such limitation or exclusion ends. The other group health coverage shall be primary for all health services except those health services that are subject to the preexisting condition limitation or exclusion.

F. The date, after electing continuation Coverage, that the Qualified Beneficiary first becomes entitled to Medicare, except that this shall not apply in the event the Qualified Beneficiary's Coverage was terminated because the Enrolling Group filed for bankruptcy, in accordance with qualifying event (F) described in Section 4.3.

G. The date the entire Policy ends.

H. The date Coverage would otherwise terminate under the Policy.

If a Qualified Beneficiary is entitled to 18 months of continuation and a second Qualifying Event occurs during that time, the continuation Coverage of a Qualified Beneficiary who is an Enrolled Dependent may be extended up to a maximum of 36 months from the Qualifying Event described in Section 4.3 A. If a Qualified Beneficiary is entitled to continuation because the Enrolling Group filed for bankruptcy, in accordance with Qualifying Event (F) described in Section 4.3 and the retired Subscriber dies during the continuation period, the Enrolled Dependents shall be entitled to continue Coverage for 36 months from the date of death. Terminating events (B) through (G) described in this Section 4.5 shall apply during the extended continuation period.

Continuation Coverage for Qualified Beneficiaries whose continuation Coverage terminates because the Subscriber becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Enrolling Group's designated plan administrator for information regarding the continuation period.

SECTION 5 - REIMBURSEMENT

You are responsible to present your ID card at the time of your dental appointment so that the Dental Office can get your Policy information. The Dentist may also contact DENCAP for eligibility and your plan coverage details. The Dentist will then submit a claim for the Dental Services received at the time of your appointment. This is the standard method of reimbursement. Below outlines unusual circumstances that may require reimbursement directly to the patient.

Section 5.1 Reimbursement of Eligible Expenses. DENCAP shall reimburse you for Eligible Expenses subject to the terms; conditions, exclusions and limitations of the Policy and as described below.

Section 5.2 Filing Claims for Reimbursement of Eligible Expenses. You are responsible for sending a request for reimbursement to DENCAP's office, on a form provided by or satisfactory to DENCAP. Requests for reimbursement should be submitted within 90 days after date of service. Unless you are legally incapacitated, failure to provide this information to DENCAP within 1 year of the date of service shall cancel or reduce Coverage for the Dental Service.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

A. Your name and address

B. Patient's name and age

C. Number stated on your ID card

D. The name and address of the provider of the service(s)

E. A diagnosis from the Dentist including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim

F. Radiographs, lab or Hospital reports

G. Casts, molds or study models

H. Itemized bill which includes the CDT or ADA codes or detailed description of each charge

I. The date the dental disease began

J. A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call DENCAP at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 days of your request, send in the proof of loss with the information stated above.

Proof of Loss. Written proof of loss should be given to DENCAP within 90 days after the date of the loss. If it was not reasonably possible to give written proof in the time required, DENCAP will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service.

Payment of Claims. Benefits are payable within 45 days after DENCAP receives acceptable proof of loss. Benefits will be paid to you unless:

A. the provider notifies DENCAP that your signature is on file assigning benefits directly to that provider; or

B. you make a written request at the time the claim is submitted.

Section 5.3 Limitation of Action for Reimbursement. You do not have the right to bring any legal proceeding or action against DENCAP to recover reimbursement until 90 days after you have properly submitted a request for reimbursement, as described above. You must first use the recovery process under

the complaint and grievance procedure herein before legal action is pursued. If you do not bring such legal proceeding or action against DENCAP within 3 years of the expiration date, you forfeit your rights to bring any action against DENCAP.

SECTION 6 - PAYMENT OF CLAIMS AND APPEAL NOTICE

6.1 Post-Service Claims

Post-service claims are those claims that are filed for payment of benefits after dental care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one (1) time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

6.2 Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving dental care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from us within 15 days of receipt of the claim. If you filed a pre-service claim improperly, we will notify you of the improper filing and how to correct it within 10 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, we will notify you of the information needed within 15 days after the claim was received, and may request a one (1) time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

6.3 Urgent Claims that Require Immediate Attention

Urgent claims are those claims that require notification or a benefit determination prior to receiving dental care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Dentist with knowledge of your dental condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If you filed an urgent claim improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, we will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

6.4 Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our customer service department before requesting a formal appeal. If the customer service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a customer service representative. If you first informally contact our customer service department and later wish to request a formal appeal in writing, you should again contact customer service and request an appeal. If you request a formal appeal, a customer service representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section below and contact our customer service department immediately.

6.5 How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact us in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of dental service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

6.6 Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

6.7 Appeals Determinations

- For appeals of pre-service claims as identified above, the first level appeal will be conducted and you will be provided written or electronic notification of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.

- For appeals of **post-service claims** as identified above, the first level appeal will be conducted and you will be provided written or electronic notification of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see *Urgent Claim Appeals That Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure.

6.8 Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your dentist should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition

SECTION 7 - COORDINATION OF BENEFITS

Section 7.1 Coordination of Benefits Applicability. This coordination of benefits (COB) provision applies when a person has health and dental coverage under more than one (1) Coverage Plan. "Coverage Plan" is defined below.

The order of benefit determination rules below determine which Coverage Plan will pay as the primary Coverage Plan. The primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A secondary Coverage Plan pays after the primary Coverage Plan and may reduce the benefits it pays so that payments from all group Coverage Plans do not exceed 100% of the total allowable expense.

Section 7.2 Definitions. For purposes of this Section, Coordination of Benefits, terms are defined as follows:

A. A "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

   1. "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); and Medicare or other governmental benefits, as permitted by law.

   2. "Plan" does not include: benefits for non-medical components of group long-term care policies; individual insurance; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

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

B. The order of benefit determination rules determine whether this Coverage Plan is a "primary Coverage Plan" or "secondary Coverage Plan" when compared to another Coverage Plan covering the person.

   When this Coverage Plan is primary, its benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan's benefits. When this Coverage Plan is secondary, its benefits are determined after those of another Coverage Plan and may be reduced because of the primary Coverage Plan's benefits.

C. "Allowable expense "means a dental care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. An expense or service that is not covered by any of the Coverage Plans is not an allowable expense.

   Allowable expenses are calculated as follows:

   1. If a person is covered by 2 or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, the allowable expense is the highest of the usual and customary fees for a specific benefit.

   2. If a person is covered by 2 or more Coverage Plans that provide benefits or services on the basis of negotiated fees, the highest of the negotiated fees is the allowable expense.

   3. If a person is covered by one (1) Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the allowable expense is the primary Coverage Plan's payment arrangements.

D. "Claim determination period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

E. "Closed panel Coverage Plan" is a Coverage Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other provider, except in cases of emergency or referral by a panel member.

F. "Custodial parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one (1) half of the calendar year without regard to any temporary visitation.

Section 7.3 Order of Benefit Determination Rules. When two (2) or more Coverage Plans pay benefits, the rules for determining the order of payment are as follows:

A. The primary Coverage Plan pays or provides its benefits as if the secondary Coverage Plan or Coverage Plans did not exist.

B. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two (2) Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One (1) Plan. For a person for whom claim is made as a dependent minor child, benefits shall be determined according to the following:

   a. The primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year.

      If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

   b. Except as Provided in d. below, if the parents of the minor child are legally separated or divorced, and the parent with custody of the minor child has not remarried, the benefits of a policy or certificate that covers the minor child as a dependent of the custodial parent shall be determined before the benefits of a policy or certificate that covers the minor child as a dependent of the noncustodial parent.

   c. Except as provided in d. below, if the parents of the minor child are divorced, and the parent with custody of the child has remarried, the benefits of a policy or certificate that benefits the minor child as a dependent of the custodial parent shall be determined before the custodial parent, and the benefits of a policy or certificate that covers the minor child as a dependent of the spouse of the custodial parent, shall be determined before the benefits of a policy or certificate that covers a minor child as a dependent of the noncustodial parent.

   d. If the parents of the minor child are divorced, and the decree of divorce places financial responsibility for medical, dental or other health care expenses of the minor child upon either the custodial or noncustodial parent, the benefits of a policy or certificate that covers the minor child as a dependent of the parent with such financial responsibility shall be determined before benefits of any other policy or certificate that covers the minor child as a dependent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule labeled B(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.

Section 7.4 Effect on the Benefits of This Coverage Plan.

When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total allowable expenses.

When the benefits of this Coverage Plan are reduced as described above, each benefit is reduced in proportion. It is then charged any applicable benefit limit of this Covered Plan.

This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is not enrolled for Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in a Veterans Administration facility or other facility of the federal government. Medicare benefits are determined as if the services were provided by a non-governmental facility and covered under Medicare.
- The person is enrolled under a plan with a Medicare Medical Savings Account. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

Section 7.5 Right to Receive and Release Needed Information. Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Coverage Plan and other Coverage Plans. DENCAP 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 Coverage Plan and other Coverage Plans covering the person claiming benefits. DENCAP need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Coverage Plan must give DENCAP any facts it needs to apply those rules and determine benefit payable. If you do not provide DENCAP the information it needs to apply these rules and determine the benefits payable, your claim for benefits will be denied.

Section 7.6 Payments Made. A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, DENCAP may pay that amount to the organization that made the payment. That amount will then be treated as though it was a benefit paid under this Coverage Plan. DENCAP 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 reasonable cash value of the benefits provided in the form of services.

Section 7.7 Right of Recovery. If the amount of the payments made by DENCAP is more than it should have paid under this COB provision, it may recover the excess from one (1) or more of the persons it had 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.

SECTION 8 - SUBROGATION AND REFUND OF EXPENSES

8.1 Refund of Overpayments. If DENCAP pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to DENCAP if:

A. All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person, or

B. All or some of the payment made by DENCAP exceeded the benefits under the Policy.

The refund equals the amount DENCAP paid in excess of the amount it should have paid under the Policy.

If the refund is due from another person or organization, the Covered Person agrees to help DENCAP get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, DENCAP may reduce the amount of any future benefits that are payable under the Policy. DENCAP may also reduce future benefits under any other group benefits plan administered by DENCAP for the Enrolling Group. The reductions will equal the amount of the required refund. DENCAP may have other rights in addition to the right to reduce future benefits.

8.2 Reimbursement of Benefits Paid. If DENCAP pays benefits for expenses incurred on account of a Covered Person, the Subscriber or any other person or organization that was paid must make a refund to DENCAP if all or some of the expenses were recovered from or paid by a source other than the Policy as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount DENCAP paid.

If the refund is due from another person or organization, the Covered Person agrees to help DENCAP get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, DENCAP may reduce the amount of any future benefits that are payable under the Policy. DENCAP may also reduce future benefits under any other group benefits plan administered by DENCAP for the Enrolling Group. The reduction will equal the amount of the required refund. DENCAP may have other rights in addition to the right to reduce future benefits.

SECTION 9 - COMPLAINT AND GRIEVANCE PROCEDURE

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 Subscribers receive is one (1) of quality, DENCAP has established Internal and External Grievance Procedures.

Section 9.1 Internal Informal Grievance Process.
If a Subscriber is not satisfied with the care received from their Dentist; the Subscriber 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: info@dencap.com

If DENCAP is not able to resolve the matter, a Subscriber is encouraged to follow the Internal Formal Grievance Process below so that DENCAP can address the concerns in a prompt manner.

Section 9.2 Internal Formal Grievance Process.
If the situation is not resolved to their satisfaction through this contact with DENCAP, a Subscriber is asked to express their concerns in writing. Subscribers are to send notice to DENCAP:

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

Subscribers are instructed to include the information below with their comments:

A - Subscriber’s name.
B - Subscriber’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 Subscriber shall receive timely notification about the progress of an investigation.

A Subscriber 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 Subscriber is not satisfied with the determination, the Subscriber 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 Subscriber of the time and place of the manager meeting and of the Subscriber’s right to be present.

The Subscriber 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 Subscriber 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 Subscriber; and for a period of time that shall not exceed ten (10) business days if DENCAP has not received requested information from a dental care facility or dental professional. The only way this time frame can be extended is if the Subscriber requests an extension.

Subscribers 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 Subscriber; 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.

Section 9.3 External Review Process.
The Subscriber 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.

Subscribers 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 Subscriber 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.

Section 9.4 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 Subscriber or would jeopardize the Subscriber's ability to regain maximum function.

Telephone: 888-988-3384
Email: info@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 Subscriber 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.

Section 9.5 Grievances – Filing Time Period.
A Subscriber has 180 days from the date of discovery to file a Grievance, unless the Subscriber can show conclusively that circumstances required a longer period of time prior to filing the Grievance.

Section 9.6 Records.
DENCAP shall keep all information and dental records pertaining to Subscribers confidential. Information and records shall be maintained to the extent and degree professionally required.

Records pertaining to a Subscribers or enrolled Dependents shall be made available; when reasonably requested, for inspection and review by the Subscribers and those persons authorized by the Subscribers 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.

SECTION 10 - PROCEDURES FOR OBTAINING BENEFITS

Section 10.1 Dental Services. You are eligible for Coverage for Dental Services listed in Exhibit III of this Certificate if such Dental Services are Necessary and are provided by or under the direction of a Dentist or other provider. All Coverage is subject to the terms, conditions, exclusions and limitations of the Policy.

Before you are eligible for Coverage for Dental Services you must meet the requirements for payment of the Annual Deductible specified in Exhibit III. Providers may request that you pay all charges when services are rendered. You must file a claim with DENCAP for reimbursement of Eligible Expenses.

Section 10.2 Pre-Determination of Benefits. As defined by Exhibit I, a preauthorization for dental work on all major restoration should be sent to DENCAP. if the charge for a Dental Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you should notify DENCAP of such treatment before treatment begins. You must send the notice to DENCAP, via claim form, within 20 days of the exam. If requested the Dentist must provide DENCAP with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

DENCAP will decide if the proposed treatment is Covered under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dentist and will be subject to all terms, conditions and provisions of the Policy. If a treatment plan is not submitted, the Covered Person will be responsible for payment of any dental treatment not approved by DENCAP. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-determination of benefits is not an agreement to pay for expenses. This procedure lets the Covered Person know in advance approximately what portion of the expenses will be considered for payment.

SECTION 11 - GENERAL PROVISIONS

Section 11.1 Entire Policy. The Policy issued to the Enrolling Group, including the Certificate of Coverage, the Enrolling Group's application, Amendments and Riders, constitute the entire Policy. All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties.

Section 11.2 Limitation of Action. You do not have the right to bring any legal proceeding or action against DENCAP without first completing the complaint procedure specified in the Section entitled Complaint Procedures. If you do not bring such legal proceeding or action against DENCAP within 3 years of the date DENCAP notified you of its final decision as described in the Section entitled Complaint Procedures; you forfeit your rights to bring any action against DENCAP.

The only exception to this limitation of action is that reimbursement of Eligible Expenses, as set forth in the Section of this Certificate entitled Reimbursement, is subject to the limitation of action provision of that section.

Section 11.3 Time Limit on Certain Defenses. No statement, except a fraudulent statement, made by the Enrolling Group shall be used to void the Policy after it has been in force for a period of 2 years.

Section 11.4 Term of Agreement and Renewal. The term of agreement is twelve (12) months unless otherwise specified differently in Exhibit III and commences on the group effective date. The agreement shall automatically renew month to month until the party provides notice to the other party at least thirty (30) days prior.

Section 11.5 Amendments and Alterations. Amendments to the Policy are effective upon 31 days written notice to the Enrolling Group. Riders are effective on the date specified by DENCAP. No change will be made to the Policy unless it is made by an Amendment or by a Rider that is signed by an officer of DENCAP. No agent has authority to change the Policy or to waive any of its provisions.

Section 11.6 Relationship Between Parties. The relationships between DENCAP and providers and relationships between DENCAP and Enrolling Groups, are solely contractual relationships between independent contractors. Providers and Enrolling Groups are not agents or employees of DENCAP, nor is DENCAP or any employee of DENCAP an agent or employee of providers or Enrolling Groups.

The relationship between a provider and any Covered Person is that of provider and patient. The provider is solely responsible for the services provided to any Covered Person.

The relationship between the Enrolling Group and Covered Persons is that of employer and employee, Dependent or other Coverage classification as defined in the Policy. The Enrolling Group is solely responsible for enrollment and Coverage classification changes, including termination of a Covered Person's Coverage through DENCAP, for the timely payment of the Policy Charge to DENCAP, and for notifying Covered Persons of the termination of the Policy.

Section 11.7 Assignment. Either party may assign this contract with thirty (30) days written notice to the other party.

Section 11.8 Records. You must furnish DENCAP with all information and proofs that it may reasonably require regarding any matters pertaining to the Policy.

By accepting Coverage under the Policy, you authorize and direct any person or institution that has provided services to you, to furnish DENCAP any and all information and records or copies of records relating to the services provided to you. DENCAP has the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

DENCAP agrees that such information and records will be considered confidential. DENCAP has the right to release any and all records concerning dental care services which are necessary to implement and administer the terms of the Policy or for appropriate review or quality assessment.

DENCAP is permitted to charge you reasonable fees to cover costs for completing requested dental records or forms that you have requested.

In some cases, DENCAP will designate other persons or entities to request records or information from or related to you and to release those records as necessary. DENCAP's designees have the same rights to this information, as does DENCAP.

During and after the term of the Policy, DENCAP and its related entities may use and transfer the information gathered under the Policy for research and analytic purposes.

Section 11.9 ERISA. When the Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the Employee Retirement Income Security Act 29 U.S.C. §1001 et seq., DENCAP is not the plan administrator or named fiduciary of the welfare plan, as those terms are used in ERISA.

Section 11.10 Examination of Covered Persons. In the event of a question or dispute concerning Coverage for Dental Services, DENCAP may reasonably require that a Dentist acceptable to DENCAP examine you at DENCAP's expense.

Section 11.11 Clerical Error. If a clerical error or other mistake occurs, that error shall not deprive you of Coverage under the Policy. A clerical error also does not create a right to benefits.

Section 11.12 Notice. When DENCAP provides written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons.

Section 11.13 Workers' Compensation Not Affected. The Coverage provided under the Policy does not substitute for and does not affect any requirements for coverage by workers' compensation insurance.

Section 11.14 Conformity with Statutes. Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

Section 11.15 Non-Liability. A Covered Person may, for personal or religious reasons, refuse to accept procedures or treatment recommended as Medically Necessary by his or her Dentist. Although it is the Covered Person's right to refuse treatment, in some situations such refusal may be regarded as a barrier to the continuance of the Dentist-patient relationship or to the rendering of the appropriate standard care.

When a Covered Person refuses a recommended Medically Necessary treatment or procedure, the Covered Person will be advised if the Dentist believes that no professionally acceptable alternative treatment exists. If the Covered Person continues to refuse the treatment or procedure, the Dentist is relieved of further professional responsibility to provide care for the condition which requires treatment and DENCAP will have no further obligation to provide Coverage for treatment of the condition.

EXHIBIT I - Schedule of Covered Benefits

Type 1 - PREVENTATIVE

Diagnostic & Preventative

Code		Description
9999/9430	a	Office Visit (regular hours)/Office visit (observation only)
0120	a	Periodic Oral Evaluation
0140	a	Limited Oral Evaluation - Problem Focused
0150	a	Comprehensive Oral Evaluation
0431		Prediagnostic Test
1110	a	Prophylaxis/Routine Cleaning - Adult
1120	a	Prophylaxis/Routine Cleaning - Child
1206	b	Topical Application of Fluoride Varnish
1208	b	Topical Application of Fluoride - Excluding Varnish
1330		Oral Hygiene Instructions
9215		Local Anesthesia

Radiographs

Code		Description
0210	d	Intraoral - Complete Series
0220	e	Periapical - First radiographic image
0230	e	Periapical - Each Additonal radiographic image
0240	e	Intraoral - Occlusal radiographic image
0270	e	Bitewing - Single radiographic image
0272	e	Bitewings - Two radiographic images
0273	e	Bitewings - Three radiographic images
0274	e	Bitewings - Four radiographic images
0330	d	Panoramic radiographic image

Type 2 - BASIC

Adjunctive Services

Code		Description
0470	f	Diagnostic Casts (each)
1351/53	f	Sealant or repair to Sealent - per tooth
1510	f	Unilateral - fixed (space maintainers)
1515	f	Bilateral - fixed (space maintainers)
1520	f	Unilateral - removable (space maintainers)
1525	f	Bilateral - removable (space maintainers)
1550	f	Re-cement or re-bond space maintainer
2910	f	Re-cement inlay, onlay, veneer or partial coverage restoration
2915	f	Recement indirectly fabricated or prefabricated post and core
2920	f	Re-cement or re-bond crown
2940	f	Protective Restoration (sedative filling)
6930	f	Re-cement or re-bond fixed partial denture
9110	f	Pallative (Emergency) Treatment, minor procedure
9310	f	Consultation (Second Opinion)
9910	f	Application of Desensitizing Medicament
9930	f	Treatment of Complications (post-surgical) - unusual circumstances
9940	f	Occlusal Guard (night guard)
9951	f	Occlusal Adjustment (limited)

Prosthetic Repair

Code		Description
5410/11/21/22	c	Denture/Partial adjustment (existing)
5510/5610	p	Repair denture/partial (resin base)
5520/5640	f	Replace missing/broken tooth on denture/partial
5620/30	f	Partial cast framework/Repair or replace broken clasp
5650	f	Add tooth to existing partial denture
5660	f	Add clasp to existing partial denture
5730/31/40/41	f	Reline complete or partial denture (office)
5750/51/60/61	f	Reline complete or partial denture (lab)

Restorative

Code		Description
2140	f	Amalgam Filling - One Surface
2150	f	Amalgam Filling - Two Surfaces
2160	f	Amalgam Filling - Three Surfaces
2161	f	Amalgam Filling - Four or More Surfaces
2330	f	Composite Filling - One Surface (Anterior)
2331	f	Composite Filling - Two Surfaces (Anterior)
2332	f	Composite Filling - Three Surfaces (Anterior)
2335	f	Composite Filling - Four Surfaces (Anterior)/IA
2391	f	Composite Filling - One Surface (Posterior)
2392	f	Composite Filling - Two Surfaces (Posterior)
2393	f	Composite Filling - Three Surfaces (Posterior)
2394	f	Composite Filling - Four Surfaces (Posterior)

Simple Extractions

Code		Description
7111	k	Extraction - coronal remnants (deciduous tooth)
7140	k	Extraction - erupted tooth or exposed root

Type 3 - MAJOR

Crowns

Code		Description
2390		Crown - resin-based composite (anterior)
2751	g	Crown - porcelain fused to predominantly base metal
2752	g	Crown - porcelain fused to noble metal
2781/6781	g	Crown - 3/4 cast predominantly base metal
2782/6782	g	Crown - 3/4 cast noble metal
2791/6791	g	Crown - full cast predominantly base metal
2792/6792	g	Crown - full cast noble metal
2799		Crown - provisional
2930/31/32/33		Crown - prefabricated stainless steel/resin
2950	g	Core Buildup (including any pins)
2952	g	Post and Core in addition to Crown
2954	g	Prefabricated Post and Core in addition to Crown
6751	g	Crown - porcelain fused to predominantly base metal
6752	g	Crown - porcelain fused to noble metal
2542/43/44	g	Onlay - metallic
2642/43/44	g	Onlay - porcelain/ceramic
2662/63/64	g	Onlay - resin-based composite

Type 3 - MAJOR (continued)

Endodontics

Code	Limit	Procedure
3110/20		Pulp Cap (direct/indirect)
3220		Therapeutic Pulpotomy
3310	i	Anterior Root Canal Therapy
3320	i	Bicuspid Root Canal Therapy
3330	i	Molar Root Canal Therapy
3346	i	Retreat of Previous Root Canal Therapy, anterior
3347	i	Retreat of Previous Root Canal Therapy, bicuspid
3348	i	Retreat of Previous Root Canal Therapy, molar
3410	i	Apicoectomy/Periradicular Surgery, anterior
3421	i	Apicoectomy/Periradicular Surgery, bicuspid (first root)
3425	i	Apicoectomy/Periradicular Surgery, molar (first root)
3426	i	Apicoectomy/Periradicular Surgery (each additional root)
3430		Retrograde Filling (per root)

Oral Surgery

Code	Limit	Procedure
7210	k	Surgical removal of an erupted tooth
7220	k	Removal impacted tooth - soft tissue
7230	k	Removal impacted tooth - partially bony
7240	k	Removal impacted tooth - completely bony
7241	k	Removal impacted tooth - completely bony (complicated)
7250	k	Surgical removal of residual tooth roots
7280	k	Surgical access of an unerupted tooth
7310	l	Alveoloplasty in conjunction with extractions (4+ teeth or spaces)
7311	l	Alveoloplasty in conjunction with extractions (1-3 teeth or spaces)
7320	l	Alveoloplasty not in conjunction with exts. (4+ teeth or spaces)
7321	l	Alveoloplasty not in conjunction with exts. (1-3 teeth or spaces)
7471/2/3	l	Removal of exostosis/torus (per site)
7510	k	Incision and drainage of abscess (intraoral soft tisue)
9230		Inhalation of nitrous oxide
9241		IV moderate (conscious) sedation/analgesia (first 30 mins)
9242		IV moderate (conscious) sedation/analgesia (each addional 15 mins)

Periodontics

Code	Limit	Procedure
0180	p	Comprehensive Periodontal Evaluation
4210	l	Gingivectomy/Gingivoplasty (4+ teeth or spaces)
4211	l	Gingivectomy/Gingivoplasty (1 - 3 teeth or spaces)
4240	l	Gingival Flap Procedure (4+ teeth or spaces)
4241	l	Gingival Flap Procedure (1 - 3 teeth or spaces)
4260	l	Osseous Surgery (4+ teeth or spaces)
4261	l	Osseous Surgery (1 - 3 teeth or spaces)
4341	h	Perio Scaling/Root Planing (4+ teeth)
4342	h	Perio Scaling/Root Planing (1 - 3 teeth)
4355	m	Full Mouth Debridement
4381		Site Specific Therapy (per tooth) - generic
4381		Site Specific Therapy (per tooth) - Arestin ©
4910	n	Periodontal Maintenance
4921	o	Gingival Irrigation - per quad

Prosthodontics

Code	Limit	Procedure
5110/20	j	Complete Upper/Lower Denture
5130/40	j	Immediate Upper/Lower Denture
5211/12	j	Partial Upper/Lower Denture - resin base
5213/14	j	Partial Upper/Lower Denture- cast metal framework with resin bases (including conventional clasps, rests and teeth)
5820/21	j	Partial Denture (interim)
5850/51	j	Tissue Conditioning (per arch)
6010/12	j	Endosteel implant in conjunction with denture
6211	j	Pontic - cast predominantly base metal
6212	j	Pontic - cast noble metal
6241	j	Pontic - porcelain fused to predominantly base metal
6242	j	Pontic - porcelain fused to noble metal

a Once every six months
b Once every six months in conj. With prophylaxis
c 2 Per month
d Once every 3 years (36 months)
e As needed (limited to no more than 8 films per occurrence)
f Once every 2 years, per tooth or quadrant
g Once every 5 years, per tooth
h Once every 12 months, per tooth or quadrant
i Once per lifetime, per tooth
j Once every 5 years
k Once per lifetime, per tooth
l Once every 3 years (36 months), per quadrant, site or tooth
m Once every 2 years
n Once every 3 months, maximum of 4 visits per year
o Once every 6 months, in conjunction with periodontal cleaning
p One per year

EXHIBIT II – GENERAL EXCLUSIONS

Section 12.1 Exclusions. Except as may be specifically provided in the Section entitled Covered Services or through a Rider to the Policy, the following are not Covered:

A. Dental Services that are not Necessary.

B. Hospitalization or other facility charges.

C. Any dental procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)

D. Reconstructive Surgery regardless of whether or not the surgery which is incidental to a dental disease, injury, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body.

E. Any dental procedure not directly associated with dental disease.

F. Any procedure not performed in a dental setting.

G. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.

H. Placement of dental implants, implant-supported abutments and prostheses. This includes pharmacological regimens and restorative materials not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

I. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.

J. Services for injuries or conditions covered by Workers' Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.

K. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

L. Treatment of malignant or benign neoplasms, cysts, or other pathology, except excisional removal. Treatment of congenital malformations of hard or soft tissue, including excision.

M. Replacement of complete or partial dentures, fixed bridgework, or crowns previously submitted for payment under the Plan within five (5) years of initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

N. Replacement of complete or partial dentures, crowns, or fixed bridgework if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.

O. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.

1P. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.

Q. Expenses for dental procedures begun prior to the Covered Person's eligibility with the Plan.

R. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.

S. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures,

any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.

T. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).

U. Full mouth radiograph series in excess of once every five (5) years. Panoramic radiographs in excess of once every five (5) years, except when taken for diagnosis of third molars, cysts, or neoplasms.

V. Denture relines for complete or partial conventional dentures for the six (6) month period following the insertion of a prosthesis. Tissue conditioning and soft and hard relines for immediate full and partial dentures for the six (6) months. After the six (6) month waiting period, relines are covered not more than once every twelve (12) months.

W. Root planing and scaling (ADA Code 4341/4342) in excess of once every twelve (12) months per quadrant.

X. Hard tissue periodontal surgery and soft tissue periodontal surgery per surgical area in excess of once in any thirty-six (36) month period. This includes gingivectomy, gingivoplasty, gingival curettage (with or without a flap procedure), osseous surgery, pedicle grafts, and free soft tissue grafts.

Y. Osseous grafts, with or without resorbable or non-resorbable GTR membrane placement in excess of once every thirty-six (36) months per quadrant or surgical site.

Z. Replacement of crowns, bridges, and fixed or removable prosthetic appliances inserted prior to plan coverage unless the patient has been eligible under the plan for twelve (12) continuous months. If loss of a tooth requires the addition of a clasp, pontic, and/or abutment(s) within this twelve (12) month period, the plan is responsible only for the procedures associated with the addition.

AA. Replacement of missing natural teeth lost prior to the onset of plan coverage until the patient has been eligible for twelve (12) continuous months. If teeth were extracted under the prior carrier’s plan, the missing teeth clause is waived.

BB. Billing for incision and drainage (ADA Code 7510) if the involved abscessed tooth is removed on the same date of service.

CC. Full mouth debridement (ADA Code 4355) in excess of once every twenty-four (24) months.

DD. Occlusal guards except if prescribed to control of habitual grinding, including those specifically used as safety items or to affect performance primarily in sports-related activities.

EE. Placement of fixed bridgework solely for the purpose of achieving periodontal stability.

FF. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.

GG. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.

HH. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.

II. General Anesthesia, except if required for patients under six (6) years of age or patients with behavioral problems or physical disabilities.

JJ. Orthodontic Services. See Exhibit III for any deviations.

KK. In the event that a Non-Network provider routinely waives Copayments and/or the Annual Deductible for a particular Dental Service, the Dental Service for which the Copayments and/or Annual Deductible are waived is not Covered.

LL. Services that are covered by Health Insurance.

MM. Restorations – Replacement or repair of a restoration is the provider’s responsibility for the first two (2) years following its placement. This applies to all restorations.

NN. Crowns are only covered if/when previous root canal therapy has been successfully completed within five (5) years. The tooth must be deemed sound and otherwise restorable prior to placement of the crown in order for the restoration to be covered.

OO. Root canal therapy is a benefit only where otherwise sound teeth can be reasonably restored and the condition of the rest of the mouth supports this method of treatment.

PP. Retreatment of previous root canal therapy requires the removal of all previous root canal materials and the necessary preparation of the canals for a new root canal filling materials. It includes all procedures necessary for complete root canals therapy and should be considered prior to performing an apicoectomy. Prior Authorization request must include a periapical image and documentation of the reason for retreatment. Retreatment of root canal therapy is not covered if the following conditions exist:

1. Where furcation pathology exists
2. In unopposed posterior teeth.
3. Where teeth are not restorable.

Apicoectomy should only be done after a tooth has had at least one (1) root canal procedure and retreatment has not been successful or is not possible.

QQ. Complete or partial dentures are NOT authorized if:

1. A previous prosthesis has been provided within the five (5) years, whether or not the existing denture was obtained with the current coverage.
2. An adjustment, reline, repair or duplication will make the current prosthesis serviceable.

RR. Any combination of 10 or more intraoral/bitewing radiographs will be considered a full mouth series.

SS. Retrograde filling is covered in conjunction with apicoectomy only

TT. Limited oral evaluation must include appropriate recording of dental/medical history and charting that is clinically appropriate for diagnosis of a specific problem. All information must be included in the patient's chart.

UU. Comprehensive oral evaluation is performed on a new patient or an established patient with significant health changes or absent from treatment three or more years. The evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues, including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions; including periodontal charting, oral cancer screening and appropriate radiographic studies.