Policy Holder/Group: 081694000P SYCAMORE TOWNSHIP-CLG GROUP

Schedule of Benefits

Benefit Plan Number: 1375

Benefit Year: The 12 month period beginning January 1st and ending December 31st (calendar year)

Annual Maximum Benefit: $2,000.00 per member

Orthodontic Lifetime Maximum Benefit: $1,000.00 per eligible member
Limited to eligible dependent children under age 19

Deductible: Deductible for services provided by an In-Network Provider
$25.00 per member, per benefit year
$75.00 per family, per benefit year

Deductible for services provided by an Out-of-Network Provider
$25.00 per member, per benefit year
$75.00 per family, per benefit year

The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	In-Network Percentage of Allowable Expense Paid by the Plan	In-Network Member Copayment	Out-of-Network Percentage of Allowable Expense Paid by the Plan	Out-of-Network Member Copayment
Preventive Benefits	No	100%	0%	100%	0%
Basic Benefits	Yes	80%	20%	80%	20%
Major Benefits	Yes	80%	20%	80%	20%
Orthodontic Benefits	No	60% Limited to eligible dependent children under age 19	40%	60% Limited to eligible dependent children under age 19	40%

Additional Covered Dental Services and Limitations:

If You have any questions about Your coverage, please feel free to contact Our Member Services Department at (513) 554-1100 or 1-800-367-9466. Questions about Your dental care should always be discussed with Your Dentist directly.

The Dental Care PLUS GROUP
A DentaQuest Company

Underwritten by Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

Amendment
Regarding Dependent Eligibility

This Amendment is made a part of the Dental Preferred Provider Organization (DPPO) Plan Certificate of Insurance or Summary Plan Description and becomes part of the Eligibility Information section. The Eligibility section is hereby amended as follows.

Coverage of Dependent Children is subject to the exclusions, limitations, conditions and other terms of the Master Group Policy.

- Coverage for Dependent Children is continued to the end of the month in which they attain age 26, regardless of financial dependency, residency, student status or marital status.
- Continuation of Coverage for Dependent Children does not include coverage for such Dependent Child's spouse or children.
- The terms of coverage cannot vary based on the age of the children.

Bob Lynn, President

The Dental Care
PLUS GROUP
A DentaQuest Company

DENTAL PREFERRED PROVIDER ORGANIZATION ("DPPO") PLAN CERTIFICATE OF INSURANCE

DENTASELECT PLUS NETWORK

Underwritten by Dental Care Plus, Inc.

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

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

DENTAL PREFERRED PROVIDER ORGANIZATION ("DPPO") PLAN

Issued and Underwritten by Dental Care Plus, Inc.
100 Crowne Point Place
Cincinnati, Ohio 45241

Certificate of Insurance

The Dental Preferred Provider Organization ("DPPO") Plan is a dental plan issued and underwritten by Dental Care Plus, Inc. which includes access to the DentaSelect Plus Network, which is a network of dentists offered by Dental Care Plus, Inc. You and any family members named on the Identification Card(s), for whom the required Dental Premium has been paid, are entitled to coverage under the Master Group Policy (referred to in this Certificate of Insurance as the "Policy" or "Plan") provided You meet the eligibility requirements stated in the Policy.

Your coverage is subject to the exclusions, limitations, conditions and other terms of the Master Group Policy. As a Certificate, this document summarizes the terms of coverage under the Policy but does not constitute the Policy. Certain terms of coverage summarized below may be modified by Amendments to the Certificate or in the Schedule of Benefits. The Schedule of Benefits and Amendments (if any) have been separately provided to You with this Certificate. It is important that You review this Certificate including any Amendments and the Schedule of Benefits carefully. You may examine the Master Group Policy at the offices of Your Enrolling Unit during regular business hours.

READ YOUR CERTIFICATE CAREFULLY.

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SECTION 1 - DEFINITIONS

Allowable Expense means the maximum allowable amount that the Policy establishes for a Covered Dental Service. The Policy will pay based on the lesser of the actual billed charge or the Allowable Expense, subject to the coverage levels referenced in the Schedule of Benefits. If services are obtained from an Out-of-Network Provider, the Member is responsible for payment to the Dentist for the difference between the Dentist's actual charge and the Policy's Allowable Expense.

Annual Maximum Benefit is the maximum amount payable under the Policy for Covered Dental Services received by a Member in a Benefit Year.

Benefit Year means the 12 month period for which benefits under the Policy are calculated. Your Benefit Year is specified in the Schedule of Benefits.

Copayment is the amount which the Member is required to pay for certain dental services covered under the Policy. Copayments may be a fixed dollar amount or a percentage of the Allowable Expense. The Member is responsible for payment of the Copayment directly to the Dentist. See the Schedule of Benefits for Copayment levels.

Covered Dental Services/Covered Services are services for which benefits are provided under the Policy and for which We will pay all or part of the Allowable Expense, subject to the exclusions, limitations, conditions and other terms of the Policy. Covered Dental Services are described in the Covered Dental Services section of this Certificate and in the Schedule of Benefits. Covered Dental Services do <u>not</u> include services that exceed any Policy limitations or maximum benefit levels.

Deductible is the amount which the Member is required to pay for Covered Dental Services before benefits are payable under the Policy. The Deductible amount is shown in the Schedule of Benefits.

Dental Preferred Provider Organization ("DPPO") Plan is a PPO dental plan issued and underwritten by Dental Care Plus, Inc. of Cincinnati, Ohio. Also hereinafter referred to as "We", "Us" and "Our".

Dental Premium means the amount which is payable by the Enrolling Unit and/or the Subscriber for coverage under the Policy.

Dentist means a person who is a legally licensed doctor of dental surgery, dental medicine or dental science in the state where services are rendered and who is acting within the scope of that license.

Emergency means a dental condition characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate dental attention could reasonably result in:

- permanently placing the Member's health in jeopardy:
- causing other serious dental or health consequences; or
- causing serious impairment of dental function.

Enrolling Unit means the Employer or other entity with whom the Policy is made.

Family Dependent means a spouse or Dependent Child of a Subscriber who is enrolled in the Policy and eligible for coverage under the Policy. See Eligibility Information for specific guidelines regarding eligibility.

Immediate Family means a person who is related to a Member in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother and stepsister), or child.

In-Network Provider means a Dentist who is part of the DentaSelect Plus Network and who has entered into an agreement with Us or our subcontracted vendor to provide Covered Dental Services to Members.

Lifetime Maximum Benefit is the maximum amount payable under the Policy for Covered Dental Services received by a Member during the Member's lifetime.

Medically Necessary/Medical Necessity means that the treatment, services, or supplies received by a Member are determined by Us to be:

1. appropriate and necessary for the symptoms, diagnosis, or direct care and treatment of the Member's condition;
2. within the standards the organized dental community deems good dental practice for the Member's condition;
3. not primarily for the convenience of the Member, the Member's Dentist or another person or provider;
4. not investigational or unproven, as recognized by the organized dental community, or which are used for any type of research program or protocol; and
5. not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment.

The fact that a Dentist may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make the treatment Medically Necessary or make the charge a Covered Dental Service under the Policy.

Member means the Subscriber and Family Dependents enrolled under the Policy who are eligible to receive Covered Dental Services under the Policy.

Out-Of-Network Provider means a Dentist who is not part of the DentaSelect Plus Network and has <u>not</u> entered into an agreement with Us or our subcontracted vendor.

Placed for Adoption means the assumption or retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of that legal obligation.

Policy means the Policy providing the benefits described herein issued to the Policyholder.

Policyholder, Employer means the entity, in whose name the Policy is issued, as specified in the Schedule of Benefits

Subscriber, Employee, You, Your means any employee, eligible by virtue of employment and proper enrollment, to receive Covered Dental Services provided under the Policy.

SECTION 2 - ELIGIBILITY INFORMATION

Eligible Family Dependents are a Subscriber's legally married spouse and unmarried Dependent Children, as defined below.

Under the Policy, Your eligible Family Dependents are defined as:

- Your legally married spouse
- Your or Your legally married spouse's unmarried Dependent Children defined as:
  - Biological child(ren)
  - Child(ren) named in a divorce decree or Qualified Medical Child Support Order as being the responsibility of the Subscriber for dental benefits coverage.
  - Legally adopted child(ren), foster child(ren), or child(ren) for which You have legal custody.
  - Child(ren) who have been Placed for Adoption with You, if legal adoption is anticipated but not yet finalized.
  - Child(ren) of any age who are incapable of self-support because of permanent mental or physical disability, if the mental or physical disability occurred before attainment of age 19. The Subscriber must principally support the disabled Dependent Child and proof of the permanent disability must be submitted to Us.

Unmarried Dependent Children (who are not disabled) can be covered until:

- The end of the month in which they attain age 19; or
- The end of the month in which they attain age 25 if they are enrolled as full-time students at an accredited educational institution, carrying at least twelve credit hours per quarter or semester. Evidence of full-time student status must be furnished to Us annually or more frequently as requested. In addition, a Dependent Child age 25 must not be employed on a full-time basis and must not be covered under any employee group insurance, other than either parent's group coverage, in order to remain covered under the Policy as a Dependent Child; or
- The end of the month in which they are no longer enrolled as full-time students.

In no event shall the term Family Dependent include (a) a spouse, domestic partner or Dependent Child on active duty in any military service of any country, (b) a Dependent Child who is eligible for coverage under the Policy as a Subscriber, (c) the spouse or domestic partner of a Dependent Child, or (d) the child of a Dependent Child unless that child is Your Dependent Child.

SECTION 3 - ENROLLMENT AND EFFECTIVE DATE OF INDIVIDUAL COVERAGE

Enrollment

An eligible Employee may enroll himself or herself and any Family Dependent during the initial eligibility period by completing an enrollment form provided by Us and made available by Your Employer. A newly acquired Family Dependent is eligible to enroll under the Policy for a period of thirty-one (31) days beginning on the date he or she becomes a Family Dependent.

The Enrolling Unit shall notify Us in writing of any enrollments, terminations or changes in the coverage classification of any Member. The time period of notification cannot exceed thirty-one (31) days following the effective dates of such changes.

Effective Date of Coverage

The coverage of a Member shall become effective on the date the Policy takes effect, or as otherwise specified in the Enrolling Unit's application.

Unless otherwise provided by the Policy, a Subscriber not actively at work (except while on paid vacation or unpaid leave under FMLA) on the date the Policy takes effect, shall have his coverage become effective on the date of his return to active work.

In no event shall a Family Dependent of any Subscriber be covered under the Policy until the Subscriber's coverage becomes effective.

Changes in Policy Coverage

You can change Your level of coverage before the next annual enrollment period only if You experience a change in Your family status. If You experience a change in family status and wish to change Your level of coverage, You must submit written notification to Us within 31-days* of Your change in family status. We reserve the right to require You to submit proof of any change of status. The following are examples of qualifying events for a change in family status:

- marriage
- divorce
- birth or adoption of a Dependent Child
- death of a Family Dependent
- loss of Your spouse's employment
- employment of Your spouse
- You are called to active military duty and obtain a military leave of absence

- You change from full-time status to part-time status or vice versa
- You change from active status to an unpaid leave of absence
- Your spouse's change from full-time status to part-time status or vice versa
- Your spouse's change from active status to an unpaid leave of absence
- a spouse's change in employment that significantly changes Your spouse's or Your own dental care coverage

Newborn Children: Your newborn child is automatically covered from the moment of birth until such child is thirty-one (31) days old. You must notify us within thirty-one (31) days of such birth, and pay the required additional Dental Premium, if any, in order to have coverage for the newborn child continue beyond such thirty-one (31) day period.

*The 31-day notification period is waived if court/administrative ordered coverage is required for a Dependent Child. This waiver applies when written notification/enrollment is made by either the Subscriber or other parent. The Dependent Child's coverage will not be terminated unless the Subscriber's coverage is terminated, the court/administrative order has expired or other comparable coverage is in effect.

SECTION 4 – ACCESSING BENEFITS

Identification Card

You will be issued Identification Card(s) which will list the names of all enrolled Family Dependents and which will indicate You are covered under the DPPO Plan with access to the DentaSelect Plus Network. The Identification Card should be presented whenever dental services are being received. This will assist in assuring that bills for Covered Dental Services are sent directly to Us.

If any Member permits an individual who is not a Member to use his or her Identification Card to obtain Covered Dental Services, We will terminate the coverage of the Subscriber and his or her Family Dependents effective immediately upon written notice. Any Member involved with the misuse of an Identification Card will be liable to Us for any services rendered in connection with the misuse.

Provider Network

Your coverage under the Policy includes access to the DentaSelect Plus Network. A Member is free to obtain dental care from the Dentist of his or her choice, but the Member's out-of-pocket expenses may be less in the case of treatment received from a Dentist who participates in the DentaSelect Plus Network (also referred to as an In- Network Provider.) A complete list of Dentists who participate in the DentaSelect Plus Network is available on the Dental Care Plus, Inc. website at www.dentalcareplus.com. The percentage payable by Us for Covered Dental Services is shown in the Schedule of Benefits. Services rendered to a Member by an In-Network or an Out-of-Network Provider are paid under the Policy as shown in the Schedule of Benefits.

Covered Dental Services incurred in the event of an Emergency, regardless of whether the Dentist is an In-Network or Out-of-Network Provider, shall be paid in accordance with the Schedule of Benefits, without further deductions, subject to all Policy maximums, limitations, conditions, and exclusions.

We do not make any representation or warranty as to the medical competence or ability of an In-Network Provider or an Out-of-Network Provider or to their respective staffs or Dentists. We shall not have any liability or responsibility, either direct, indirect, vicarious or otherwise, for any actions or inactions, whether negligent or otherwise, of the In-Network Provider or Out-of-Network Provider, their staffs or Dentists.

SECTION 5 – BENEFIT PROVISIONS

Allowable Expenses

Allowable Expense is the maximum allowable amount established for a Covered Dental Service. The Policy will pay based on the lesser of the actual billed charge or the Allowable Expense subject to the payment levels referenced in the Schedule of Benefits.

When Covered Services are obtained from an In-Network Provider, the Member is not responsible for the difference between the Dentist's actual charge and the Policy's Allowable Expense.

When Covered Services are obtained from an Out-of-Network Provider, the Member is responsible for payment to the Dentist for the difference between the Dentist's actual charge and the Policy's Allowable Expense.

The Member is responsible for payment of the following, regardless of whether services were obtained from an In-Network Provider or an Out-of-Network Provider:

- Copayments;
- Deductible amounts; and
- Any amount in excess of Annual or Lifetime Maximum Benefit levels.

Copayment and Maximum Benefits

Copayments are amounts that are directly payable by a Member to the Dentist for Covered Dental Services. Your Policy may also have an Annual or Lifetime Maximum Benefit level, after which no benefits are payable under the Policy. You are responsible for payment to the Dentist of any amount in excess of Annual or Lifetime Benefit levels. See the Schedule of Benefits for Copayment and Annual and Lifetime Maximum Benefit levels.

Deductible Provision

The Deductible is the amount which the Member is required to pay for Covered Dental Services before benefits are payable under the Policy. Your Deductible is per covered Member, per Benefit Year. The Deductible amount is identified in the Schedule of Benefits. Your Deductible is calculated on the Allowable Expense for Covered Services received by a Member. If the Dentist's actual charge for a Covered Service is greater than the Allowable Expense, the difference between the Dentist's actual charge and the Allowable Expense will not be counted toward Your Deductible.

After You pay the Deductible, Your coverage under the Policy pays a portion of the remaining Allowable Expenses up to the specified maximum(s). You pay for the balance of the Allowable Expense, which is Your Copayment.

Deductible Carryover

Any Allowable Expenses incurred in the last three months of the Benefit Year which were applied toward the Deductible, may be carried forward and applied against the Deductible for the next following Benefit Year.

Financial Obligation for Non-Covered Services

The Member is responsible for payment to the Dentist for any service that is not covered by the Policy. Non-covered services include (but are not limited to) the following:

- any service specifically listed as an exclusion of the Policy in this Certificate.
- any service not covered due to a specified limitation of the Policy. For examples of such limitations, please see the Covered Dental Services section of this Certificate.
- any service that is denied because a Member has exceeded the Annual or Lifetime Maximum Benefits payable under the Policy. See the Schedule of Benefits for the Annual and Lifetime Maximum Benefit levels of Your Policy.

Alternative Benefit Policy

Many dental conditions can be treated in more than one way. The Policy has an "alternative benefit policy" which governs the amount of benefits We will pay for treatments covered under the Policy. If two or more alternative treatments are both covered under the Policy, and You choose a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the covered treatment within accepted standards of dental practice at the most cost-effective level. The Member will pay the difference in cost.

SECTION 6 - COVERED DENTAL SERVICES

All payments made by Us under the Policy for Preventive, Basic, and Major services will apply to the Annual Maximum Benefit referenced in the Schedule of Benefits. The dental services listed below are covered under the Policy unless the Schedule of Benefits or an Amendment to this Certificate indicates the services are excluded or limited. We will pay for Covered Services provided by a Dentist licensed to provide such services in the state or territory where the Covered Services are being provided.

NOTE: *Some of the dental services listed in this section may not be covered under the Policy, or may be subject to different limitations than those described in this section. To the extent the Schedule of Benefits or an Amendment to this Certificate excludes a Covered Service which is listed in this Section, applies a different limitation to a Covered Service than described in this Section, or adds as a Covered Service a service which is not listed in this section, the description in the Schedule of Benefits or the Amendment will apply. Please review the Schedule of Benefits and any Amendments to this Certificate carefully when determining which dental services are covered under the Policy.*

<u>Preventive Benefits</u>

Preventive & Diagnostic Services

Service	Limitation
Routine oral examinations......................	limited to two visits each year
Prophylaxis (cleaning)	limited to two each year
Topical application of fluoride...............	limited to two treatments each year to children under age 18
Bitewing xrays	limited to one set each year
Vertical Bitewing xrays .... (7 - 8 films)	limited to once every three years
Periapical xrays	limited to 5 films per year
Full mouth x-rays .... (complete series or panoramic)	limited to once every three years

<u>Basic Benefits</u>

Emergency Services

Service	Limitation
Emergency/limited oral examinations	
Office visit after hours............................	for emergencies only
Emergency palliative treatment	

Diagnostic Services

Extraoral xrays

Referral consultations and examinations performed by a specialist

Sealants & Preventive Resin Restorations

Permanent molar teeth only .... limited to children under 15 years of age and once every five years per tooth

Space Maintainers

Space maintainer – fixed, unilateral.. limited to children under 19 years of age

Distal shoe space maintainer – fixed, unilateral .... limited to children under 8 years of age

Oral Surgery (Includes local anesthesia and routine postoperative care)

Extractions

Simple single tooth extractions

Root removal - exposed roots

Surgical Extractions

Removal of an erupted tooth (uncomplicated)

Other Oral Surgery

Incision and drainage of abscess

Biopsy and examination

General anesthesia or intravenous sedation .... only when necessary and provided in connection with oral surgery.

Periodontic Services (Includes local anesthesia and routine postoperative care)

Emergency treatment (periodontal abscess, acute periodontitis, etc.)

Periodontal scaling and root planing .... limited to four quadrants each year, as a definitive treatment when pocket depths of at least 4mm are demonstrated.

Service	Limitation
Scaling in presence of generalized moderate or severe gingival inflammation	limited to once in a 24 month period when clinical documentation demonstrates that 30% or more of teeth are involved.
Surgical periodontics (including post-surgical visits)	limited to two additional recalls in the first year following complex surgery
Gingivectomy	
Osseous and muco-gingival surgery	
Gingival grafting	
Guided tissue regeneration	
Periodontal maintenance procedure	limited to two each year following a history of periodontal disease.

Endodontic Services (Includes local anesthesia and routine postoperative care)

Service	Limitation
Root canal therapy, traditional	
Retreatment of previous root canal........	must be at least three years following previous root canal treatment on the same tooth
Recalcification and apexification	

Restorative Services (Includes local anesthesia. Multiple restorations on a single surface will be considered as a single restoration.)

Service	Limitation
Restorations (amalgam, composite, sedative fillings or core buildups)..........	limited to once every two years per tooth (same surfaces only)

Pins-pin retention as part of restoration when used instead of gold or crown restoration

Stainless steel crowns when tooth cannot be adequately restored with filling material

Recementation of inlays, onlays, crowns, bridges, and space maintainers

Repairs to crowns and bridges

Prosthodontic Services

Full and partial denture repairs

Repair broken, complete or partial dentures. Replacement of broken teeth on complete or partial denture. Additions to partial denture to replace extracted natural teeth.

Major Benefits

Oral Surgery (Includes local anesthesia & routine postoperative care)

Surgical Extractions

Removal of impacted tooth - soft tissue

Removal of impacted tooth - partially bony

Removal of impacted tooth - completely bony

Removal of impacted tooth - completely bony, with complications

Surgical removal of residual roots

Pre-Prosthetic oral surgery

Alveoloplasty and vestibuloplasty

Restorative Services (*Gold restorations and crowns are covered only as treatment for decay or traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.)*

Inlays, onlays, crowns, and post & cores.. limited to once in five years on same tooth

Prosthodontic Services

Fixed bridge .... limited to one original or replacement prosthesis every five years

Complete upper or lower denture.......... limited to one original or replacement prosthesis every five years

Partial upper or lower denture................ limited to one original or replacement prosthesis every five years

Relining and rebasing .... limited to once every three years

Orthodontic Benefits

Orthodontic Benefits may not be covered under the Policy. Please refer to the Schedule of Benefits to determine whether Orthodontic Benefits are covered under the Policy.

Orthodontic Treatment may be subject to a Lifetime Maximum Benefit. Refer to the Schedule of Benefits for the Lifetime Maximum Benefit of Your Policy.

Comprehensive Orthodontic Treatment

Other Orthodontic Treatment................. (limited to one appliance per individual)

Appliance for tooth guidance

Appliance to control harmful habits

Orthodontic retention appliance

Coverage includes orthodontic procedures provided under a treatment plan that has been submitted to Us by Your Dentist. The Dentist providing this service must supply Us with films and study models upon request.

We will make an initial payment of benefits, based on the Schedule of Benefits and the initial charge submitted under the treatment plan, and additional payments will be made in installments beginning when appliances are inserted. The payments will be monthly or quarterly for the length of the estimated treatment plan. The amount of the first Member payment for the initial charge will be at the discretion of the orthodontist. Under the Policy, up to 25% of the total treatment cost may be recognized as the Initial Charge, of which Our payment will be the benefit level specified in the Schedule of Benefits.

If a Member is receiving orthodontic treatment which was covered under another company's benefit program(s) prior to the effective date of Our benefit program, We will deduct the payments made by the other company's benefit program(s) from the Policy's Lifetime Maximum Benefit. All benefits paid toward orthodontic services by all previous benefit programs will be applied to the Policy's Lifetime Maximum Benefit.

All claims determinations can be appealed to Us.

SECTION 7 - EXCLUSIONS

The following are expenses, charges and services specifically excluded from coverage under the Policy. The Member is financially obligated for payment to the Dentist of the full charge for any service that is excluded/not covered under the Policy.

1. Services performed for cosmetic reasons, including personalization or characterization of prosthetic devices and the bleaching of teeth, unless the Schedule of Benefits specifically provides for coverage of the bleaching of teeth.
2. Services or supplies which are considered experimental according to standard dental practice.
3. Charges which are incurred before the Member's effective date of coverage or after the date a Member's coverage terminates.
4. Services or procedures started prior to the effective date of the Member's coverage, with the exception of orthodontic services if covered by the Policy. Prosthetic devices and crowns will not be covered if final impressions were taken before the effective date of coverage. If final impressions were taken while coverage is in effect, but the prosthetic device or crown is installed more than thirty (30) days after the coverage terminates, then charges for the prosthetic device or crown will not be covered, unless stated otherwise elsewhere in the Policy, this Certificate or the Schedule of Benefits.
5. Dentures, implants and bridgework (including crowns and inlays forming their abutments) if in replacement of natural teeth which were extracted while the individual was not covered under the Policy.
6. Porcelain coverage on posterior crowns.
7. Missed appointment charges.
8. Completion of claim forms.
9. Replacement of lost, stolen, or broken prosthetic devices or appliances unless it is after the limitation date.
10. Analgesics, nitrous oxide, non-intravenous conscious sedation and other drugs and prescriptions.
11. Localized delivery of antimicrobial or chemotherapeutic agents.
12. Hospital related charges.
13. Appliances, restorations, and procedures other than full dentures, for the primary purpose of increasing vertical dimension, restoring the occlusion or treatment of bruxism.
14. Veneers or similar properties of crowns and pontics.
15. Services for educational purposes.
16. Splinting (if tooth does not otherwise need to be restored).

17. Services related to or arising out of employment, including self-employment, if the Member is eligible for benefits under any workers' compensation act or similar law.
18. Surgical implants or transplants of any type (including prosthetic devices, such as crowns, attached to them) and all related services, unless the Policy, this Certificate or Schedule of Benefits specifically provides for coverage of implants. If the Schedule of Benefits provides for the coverage of implants, all implant or transplant services which are outside the Covered Dental Services and limitations described in the Schedule of Benefits are excluded from coverage.
19. Services performed by other than a licensed Dentist, except for legally delegated services to a licensed hygienist or licensed expanded functions auxiliary.
20. Treatment for Temporomandibular Joint Disease (TMJ) or Myofascial Pain Dysfunction Syndromes (MPD).
21. X-rays for TMJ.
22. Orthognathic surgery.
23. Services or supplies rendered, or furnished in connection with, any duplicate appliance.
24. Services or supplies which are not Medically Necessary.
25. Expenses incurred for more than two oral examinations and/or prophylaxis treatments during a Benefit Year.
26. Expenses incurred for the replacement of amalgams, composites, sedative fillings and/or core buildups more often than once in any two (2) year period.
27. Expenses incurred for the replacement of fixed bridgework, crowns, gold restorations and jackets more often than once in any five (5) year period.
28. Expenses incurred for the replacement of partial or full dentures more often than once in any five (5) year period.
29. Expenses incurred for replacement of an existing denture which is or can be made satisfactory.
30. Expenses incurred for relining of dentures more often than once in any three (3) year period.
31. Expenses incurred for a temporary full denture.
32. Expenses incurred for the retreatment of root canals if it has not been at least three (3) years since the previous root canal treatment.
33. Expenses incurred for bone replacement grafts for ridge preservation.
34. Expenses incurred for a core buildup if an amalgam, composite restoration and/or sedative filling was completed within a two (2) year period on the same tooth.

35. Services which are determined to be eligible expenses under any medical Policy in which the Member is enrolled.
36. House calls.
37. Dental services or supplies for a condition resulting from civil disobedience, active participation in a riot or in the commission of a felony, self-inflicted injury, nonaccidental injury, or an act of war.
38. Any services not specifically listed as a Covered Dental Service.
39. Treatment by a member of the Immediate Family or a resident in the covered Employee's home; self-treatment.
40 Acid etches.
41. Expenses for the completion of periodontal charting.
42. Asepsis.
43. Claims that are not received by Us within one calendar year from the date of service.
44. Charges for services received after a Member has reached the Annual or Lifetime Maximum Benefits payable under the Policy.
45. Expenses for gold restorations and crowns, except when used as treatment for decay or traumatic injury when teeth cannot be restored with a filling material or when the tooth is an abutment to a covered partial denture or fixed bridge.

SECTION 8 - PRETREATMENT REVIEW

Pretreatment Review is a voluntary program designed to assist You and Your Dentist in understanding Your dental coverage before services are provided.

If You or Your Dentist would like to submit a treatment plan for pretreatment review, Your Dentist must file that request for pretreatment review. Requests for pretreatment review should be sent to the following address:

The Dental Care Plus Group
A DentaQuest Company
PO Box 502
Milwaukee, WI 53201-0502

When We receive a proposed treatment plan for services that are expected to exceed $400, We will review those services for coverage under the Policy. After the review is complete, Your Dentist will be provided with an estimate of the amount payable, in whole or in part (if any), by Us on the proposed treatment. Pretreatment review only provides an estimate of covered services and does not constitute a guarantee of payment. Exact benefits are determined based upon the eligibility of the Member and benefit plan in effect at the time services are actually rendered.

We will notify Your Dentist of the pretreatment estimate within a reasonable period of time appropriate to the dental circumstances, but generally not later than 15 days after receipt of the request for pretreatment review. In certain circumstances We may extend this time period for an additional 15 days, and will notify You or Your Dentist of any extension. If additional information is necessary to process Your request for pretreatment review, We will notify You or Your Dentist, and You or Your Dentist will have 45 days from receipt of the notice to provide the additional information. If You or Your Dentist do not provide the additional information within the 45 day period, Your request for pretreatment review may be denied. In cases where the additional information is provided to Us within the 45 day period, We will notify Your Dentist of the pretreatment estimate within 15 days after receipt of the additional information. The notice will inform You and Your Dentist of the specific basis for the pretreatment estimate, and describe Your right to information concerning the estimate and Your right to appeal.

We may modify a pretreatment estimate that has been approved at any time, and We will notify Your Dentist of the modification in advance and provide You with an opportunity to appeal the modification before it is effective. Your Dentist may request that the time for the treatment plan to be completed or the number of treatments included in the pretreatment estimate

be increased at any time. We will approve or deny a request for an extension of time or increase in the number of treatments within 15 days of receipt of a completed request.

Pretreatment Review of Urgent Conditions:
If Your request for pretreatment review is for treatment of an urgent condition, and failure to obtain treatment quickly would jeopardize Your health or, in the opinion of Your Dentist, would subject You to severe pain which cannot be managed without the treatment, We will process Your request for pretreatment review as soon as possible taking into account the dental circumstances, but not later than 72 hours after We receive the request. If additional information is needed to process the request, We will notify You or Your Dentist as soon as possible, but no later than 24 hours after We receive the request, and You or Your Dentist will have at least 48 hours to provide the additional information. If You or Your Dentist do not provide the additional information within the time period allowed, the request for a pretreatment estimate may be denied. If You or Your Dentist provides the additional information requested, We will notify Your Dentist of the pretreatment estimate as soon as possible, but not later than 48 hours after receipt of the additional information. The notice will include the specific basis for the estimate, and describe Your right to information concerning the estimate and Your right to appeal.

SECTION 9 – CLAIMS PROCEDURES

How to Submit a Claim

Notice of Claim. Written notice of claim must be given to Us within twenty (20) days of the receipt of Covered Dental Services, or as soon thereafter as is reasonably possible. Notice given by or on behalf of You or Your beneficiary to Us at the address below or to any of Our authorized agents, with information sufficient to identify You, shall be deemed notice to Us. If You assign Your right to receive payment under the Policy to Your Dentist, Your Dentist may submit the claim directly to Us. Assignment of claims to Your Dentist must be in writing and signed by You, and Your Dentist must submit the written assignment form with the claim. Claims should be sent to the following address:

The Dental Care Plus Group
A DentaQuest Company
PO Box 502
Milwaukee, WI 53201-0502

We will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from You or Your Dentist.

Claim forms. Upon receipt of a notice of claim, We will furnish You with the required forms for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice You shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proofs of Loss. Written proof of loss must be furnished to Us at Our office within ninety (90) days of receipt of Covered Dental Services. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

Claims Processing Procedures

Time of Payment of Claims. Upon receipt of due written proofs of loss, amounts payable under the Policy will be paid immediately upon, or within thirty (30) days after, receipt of due written proofs of loss.

If the claim is paid, payment will be sent to You or, if You assigned Your right to payment under the Policy to Your Dentist, directly to Your Dentist.

Other Claims Processing Procedures. If the claim is denied in whole or in part, We will notify You, and if the claim was filed by Your Dentist, We will also notify Your Dentist, within a reasonable period of time, but generally not later than 30 days after We receive the claim. In certain circumstances, We may extend the 30 day time period for an additional 15 days, and will notify You that the time period has been extended.

If additional information is required to process Your claim, We will notify You or Your Dentist, and You or Your Dentist will have 45 days from receipt of the notice to provide the additional information. If You or Your Dentist do not provide the additional information within the 45 day period, Your claim may be denied. In cases where the additional information is provided to Us within the 45 day period, We will notify You and Your Dentist if the claim is denied in whole or in part within 30 days after the claim was initially received or 15 days after receipt of the additional information by Us, whichever is later. The notice of a denial will inform You and Your Dentist of the specific reason for the denial, and describe Your right to information concerning the claim and Your right to appeal.

SECTION 10 - COORDINATION OF BENEFITS (C.O.B.)

COORDINATION OF THIS CONTRACTS BENEFITS WITH OTHER BENEFITS

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

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

DEFINITIONS

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

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

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

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

B. "This Plan" means, in a COB provision, the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A

contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

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

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

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

(4) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with

the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or

health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

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

- The plan covering the custodial parent;

- The plan covering the spouse of the custodial parent;

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

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

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Us any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

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

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us at 1-800-367-9466 or www.dentalcareplus.com. If You are still not satisfied, You may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at http://insurance.ohio.gov.

SECTION 11 - COMPLAINT AND APPEAL PROCEDURES

Complaint Procedures

We recognize our responsibility to provide Members with adequate methods to make inquiries and express concerns about Us. The following procedure has been established to assure that the Member will receive a response to any complaint and formal redress if appropriate.

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

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

Appeal Procedures

An appeal is a request to change a previous decision by Us on a claim or pretreatment estimate to deny, reduce or terminate benefits. An appeal must be filed in writing within 180 days following Your initial receipt of notice that benefits for a claim or pretreatment estimate have been denied, reduced or terminated. Appeals filed later than 180 days following Your initial receipt of such notice, will be denied. All appeals must be submitted in writing. If Your appeal is of a claim for urgent treatment, You may orally request an expedited appeal, but You must follow-up Your oral request in writing. Your appeal will be expedited if You (1) are hospitalized or (2) in the opinion of the treating Dentist, review under a standard timeframe could, in the absence of immediate medical attention, result in:

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

An appeal may be filed by You, Your Dentist or by an Authorized Person acting on Your behalf. An "Authorized Person" is a parent, guardian, or other person authorized to act on behalf of a Member with respect to health care decisions.

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

Appeals Department
The Dental Care Plus Group
A DentaQuest Company
PO Box 502
Milwaukee, WI 53201-0502

Include in Your letter of appeal the following information:

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

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

A final determination will be made on Your appeal. You or Your Authorized Person (and Your Dentist if Your Dentist filed the appeal for You) will be notified of the final determination as soon as possible taking into account the dental circumstances. If You are appealing a denial, reduction or termination of benefits under a claim, You will be notified not later than 30 days after We receive the appeal. If You are appealing a pretreatment estimate, You will be notified not later than 15 days after We receive the appeal. If Your appeal is expedited, You will be notified as soon as possible, but not later than 72 hours after We receive the appeal. We will notify You or Your Authorized Person (and Your Dentist if Your Dentist filed the appeal for You) of the final determination in writing, or orally followed by a written confirmation if the appeal was expedited.

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

Complaints to the Department of Insurance

If a complaint or an appeal is not resolved to Your satisfaction, You have the right to ask the Superintendent of Insurance of Ohio to review Your complaint or appeal. The address is 50 W. Town Street, Third Floor – Suite 300, Columbus, Ohio 43215; telephone (614) 644-2673 or 1-800-686-1526.

ERISA Appeals

If You are covered under a group Policy which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), You have the right to bring a civil action in court if Your appeal is not resolved through the appeals process. You must file an appeal before bringing a civil action under Section 502(a) of ERISA. If Your appeal is denied, You then have the right to file an action under 29 U.S.C. 1132, section 502(a).

SECTION 12 - TERMINATION OF MEMBER COVERAGE

Benefits for the Member under the Policy will automatically terminate on the earliest of the following dates, unless stated otherwise elsewhere in the Policy or this Certificate:

1. The date the Policy is terminated, or with respect to any specific coverage item of the Policy, the date such coverage item terminates.
2. The last day of the last month for which the required Member contribution toward the Dental Premium has been paid to Us, if the Member is required to make a contribution.
3. The date specified by the Enrolling Unit that a Subscriber or Family Dependent is no longer eligible for coverage under the terms of the Policy.
4. The date the Enrolling Unit receives written notice from the Member for termination of coverage, or the date requested by the Member in such notice, if later.
5. The date on which the Subscriber is retired or pensioned, unless a specific coverage classification is specified for retired or pensioned individuals in the Policy.
6. The date of entry into military duty, except temporary duty of thirty (30) days or less.
7. For a Dependent Child, the end of month when the child no longer qualifies as a Family Dependent.

Right of Recovery

In the event We incur and pay any claims for services rendered to any Subscriber or Family Dependent after the termination date of the Subscriber's or Family Dependent's coverage, We reserve the right to recover those payments from the Subscriber. We must initiate the recovery process no later than two years after the payment was made.

SECTION 13 - COBRA CONTINUATION COVERAGE

The following applies if your employer is subject to the requirements of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The following provisions do not fully describe COBRA continuation coverage or other rights under the Plan.

If coverage under the Plan ceases for you, your eligible spouse and your eligible dependents, under certain circumstances you, your eligible spouse and your eligible dependents may be able to continue coverage under this Plan under a federal law called COBRA. **Please contact your employer to determine if your Plan is subject to COBRA continuation coverage**.

COBRA continuation coverage is a continuation of coverage under the Plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your Dependent Children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the Plan as a Dependent Child.

If Retiree Coverage is Offered: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed by the employer and bankruptcy results in a loss of coverage of any retired employee covered under the Plan, the retired employee will be entitled to elect COBRA continuation coverage. The retired employee's spouse, surviving spouse, and Dependent Children will also be entitled to elect COBRA continuation coverage if bankruptcy results in the loss of their coverage under the Plan.

More Information About Who May be Qualified Beneficiaries: A child born to, adopted by, or placed for adoption with you during a period of COBRA continuation coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA continuation coverage for yourself. The child's COBRA continuation coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA continuation coverage lasts for your other family members. To be enrolled in the Plan, the child must satisfy the otherwise-applicable Plan eligibility requirements (for example, regarding age). Additionally, your child who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) which was received by the Plan during your period of employment with the employer is entitled to the same rights to elect COBRA continuation coverage as an eligible dependent child of yours.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator (if one has been appointed for COBRA Plan Administration) of the qualifying event.

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the employer within 60 days after the qualifying event occurs. In addition, if applicable, you must provide a certified copy of the court order granting the divorce or legal separation.

Once the employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare (Part A, Part B, or both), your divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA continuation coverage lasts up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

There are two ways (described in the following paragraphs) in which the period of COBRA continuation coverage resulting from a termination of employment or reduction of hours can be extended. You must notify your employer of a disability or a second qualifying event in order to extend the period of continuation coverage.

Disability Extension of 18-month Period of Continuation Coverage

If a qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 61st day of COBRA continuation coverage and last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the SSA's determination

within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent Children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the employer is notified of the second qualifying event within 60 days of the second qualifying event.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA continuation coverage for themselves and certain family members (if they did not already elect COBRA continuation coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, you should contact the employer for additional information. You must contact the employer promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights. COBRA continuation coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

Trade Adjustment Assistance Extension Act of 2011

The Trade Act of 2002 was updated by the Trade Adjustment Assistance Extension Act of 2011. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll–free at 1–866–628–4282. TTD/TTY callers may call toll–free at 1–866–626–4282.

If You Have Questions About COBRA

Questions concerning your COBRA continuation coverage should be addressed to your employer. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health benefits, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer.

SECTION 14 - GENERAL PROVISIONS

Entire Contract; Changes

The Policy, the application of the Policyholder, and the individual enrollment forms submitted by the Subscribers in connection with the Policy, constitute the entire contract between the parties, and all statements, in the absence of fraud, made by any applicant shall be deemed representations and not warranties, and no such statement shall void the insurance or reduce benefits thereunder unless contained in a written application. No change in the Policy shall be valid until approved by Our chief executive officer and unless such approval is indorsed on the Policy or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Pronouns

All personal pronouns used in this Certificate shall include either gender unless the context indicates otherwise.

Legal Actions

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Financial Statement

The most recent financial statement is available to Subscribers at the offices of the Dental Care Plus Group during regular business hours.

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