SUBSCRIBER CERTIFICATE

Michigan Individual Child Only Coverage

January 2024

DentaTrust
Underwritten by DCP, Inc.

DentaQuest
a Sun Life company

DQ1080 (01.24) Child Low HB/EN

Michigan DentaTrust

Underwritten by Dental Care Plus, Inc.

Michigan DentaTrust Individual Dental Plan
Policy
Child Only Coverage

Dental Care Plus, Inc. certifies that the individuals covered under this *Policy* have the right to benefits for services under the terms of this *Agreement*. This is based on the information in the application and payment of the required premiums. Please check your information for errors. This *Policy* is part of your *Agreement*.

Notice to Buyer: This *Policy* provides benefits for *dental services* only. This *Policy* provides benefits for *covered individuals* until the last day of the month in which they obtain the age of 19 only. The *Policy* does not provide any benefits for persons age 19 and older.

Please read this *Policy* carefully. If for any reason you are not satisfied with this *Policy* return the *Policy* to us within 30 days of receipt. Upon return, the *Policy* is considered void and any premiums paid are refunded. If returned, any services received during this 30 day period are solely your financial responsibility.

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

ATTEST: Dental Care Plus, Inc.
10300 Springfield Pike
Cincinnati,OH 45215

Bob Lynn,
President

Contents

Introduction

This *Policy*, including the attached *Schedule of Benefits,* the application and any applicable riders, endorsements and supplemental agreements constitute the *Agreement* between you and Dental Care Plus, Inc. (*the Plan*). Please read it carefully.

The *covered services* listed in this *Policy* are covered as of your *effective date*. Also, there are other limitations and restrictions on your *Policy*. Please see the *Schedule of Benefits* for important information on the benefits provided under your *Policy*. If you have any questions, please contact our Customer Service department at 800-436-5298.

This *Policy* permits you to get your benefits from the *dentist* of your choice. If you choose to get benefits from a *non-contracting dentist*, your out of pocket expenses, including copayments, *coinsurance* and *deductible*, may be more.

Subscriber's Rights and Responsibilities

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

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

You and *covered individuals* have the responsibility to:

- Ask questions in order to understand the dental condition and treatment. Follow recommended treatment instructions given by your *dentist*.
- Provide information to your *dentist* that is necessary to render care to you.
- Be familiar with *the Plan's* benefits, policies and procedures, by reading our written materials, or calling our Customer Service department at 800-436-5298..

Part I

Definitions

ACA: the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by The Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the *Affordable Care Act* or *ACA*.

Adverse Benefit Determination: is a decision that dental care, availability of care, continued care, or other dental health care service that is a covered benefit has been reviewed and based upon the information provided, does not meet the requirements for dental/medical necessity, appropriateness, health care setting, level of care, or effectiveness. The requested service or payment for the service is denied. Failure to respond in a timely manner to a request for a decision is an adverse benefit determination.

Agreement: refers to this *Policy*, including the *Schedule of Benefits*, application, and any applicable riders, endorsements and supplemental agreements.

Appeal: a request, filed by a *covered individual,* an *authorized representative* or a health care provider to *the Plan* to change a previous decision made*,* on a claim or pretreatment estimate to deny, reduce or terminate benefits.

Authorized representative: a person who is authorized by a *covered individual* to file a *complaint* or an *appeal* on the *covered individual's* behalf. This includes a parent, guardian, or other person authorized to act on behalf of a *covered individual*.

Benefit Period: the period that any applicable *deductibles*, annual limitations or maximums apply. The period for individual policies is the latter of January 1 or enrollment date through December 31.

Coinsurance: the percent of covered dental expenses, after the *deductible* is satisfied, which the *covered individual* must pay. Once *the Plan* pays the annual limit or maximum payment stated in the *Schedule of Benefits*, you are solely responsible for payment for all *dental services*.

Complaint: an oral or written complaint submitted as required by the *Policy's* complaint procedures. Submitted by a *covered individual*, an *authorized representative* or a *dentist* regarding any aspect of *the Plan's* organization related to a *covered individual*.

Contracting Dentist: a licensed *dentist* who has entered into an agreement, either directly or through a network contract with *the Plan,* to provide services to its *covered individuals* and who participates in the designated network for *the Plan*. A *contracting dentist* is considered In-Network. The network for *the Plan* is posted in the Provider Directory for *the Plan* and is available at Hixfadmi.dentalcareplus.com.

Copayment: a fixed amount you pay to a *dentist* for a *covered service*.

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

Covered service: a *dental service c*overed under the terms of the *Agreement* that is not otherwise limited or excluded and subject to the terms and conditions of *the Agreement*.

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

Deductible: amount you must pay in a *benefit period* for *covered services* before *the Plan* will pay benefits. The amount of the *deductible* is shown in the *Schedule of Benefits*.

Dental Service: a procedure or service rendered by a dental care provider within the scope of the license or certificate.

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

Department means The Department of Insurance and Financial Services (DIFS). The Michigan state entity that regulates insurance. The address, telephone number and other contact information for DIFS are shown in the Policy Schedule.

Dependent: children of the *subscriber* from the moment of birth up to the last day of the month in which they obtain the age of nineteen (19). Children include (i) biological children and stepchildren; (ii) children named in a divorce decree or qualified medical child support order as being the responsibility of the *subscriber* for dental benefits coverage; (iii) legally adopted children, or children for which the *subscriber* has legal custody; and (iv) children who have been placed for adoption with the *subscriber*, if legal adoption is anticipated but not yet finalized. In no event shall this coverage include a child on active duty in any military service of any country.

Director means the DIFS Director.

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

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

Expedited Grievance means the immediate actions taken by us when a *grievance* is submitted and a Dentist or physician orally or in writing, substantiates that the time frame for a *grievance* would acutely jeopardize the life or health of the *covered individual*.

Federally Facilitated Marketplace or FFM: the health benefit exchange established by *ACA* for the state of Michigan. The FFM can be reached at www.healthcare.gov or 800-318-2596.

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

Final Adverse Determination means an adverse decision involving a covered benefit that has been upheld by a health carrier, or its designee utilization review organization, at the completion of our internal *grievance* process procedures.

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

Grievance means a complaint or inquiry on behalf of the *covered individual* submitted regarding:

1. The availability, delivery, or quality of dental health care services. This includes a *complaint* about an adverse determination made pursuant to utilization review.
2. Benefits or claims payment, handling, or reimbursement for *covered services.*
3. Matters about the contractual relationship between you and us.

Individual coverage: coverage that includes only one *covered dependent*.

Injury: damage to the *covered individual's* mouth due to an accident and all complications from that damage. This does not include damage to teeth, appliances or dental prostheses that are a result of chewing or biting.

Non-Contracting Dentist: a licensed *dentist* that has not entered into an agreement with *the Plan* to provide services to its *covered individuals*. A *non-contracting dentist* is considered Out-of-Network.

Out of Pocket Maximum: the maximum amount a *subscriber* will pay (including *deductibles*, and *coinsurance*) for *covered services* in any benefit period. Any applicable *Out of Pocket Maximum* is listed in the *Schedule of Benefits*.

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

Policy: this contract of insurance including the *Schedule of Benefits*.

PRIRA means the Patient's Right to Independent Review Act. The Act provides a review of certain health care coverage adverse determinations or final adverse determinations made by health carriers

Qualified Health Plan or QHP: a stand-alone dental plan that satisfies all of the certification requirements established by the *ACA* and applicable federal regulations, is certified by and offered on the *FFM*.

Qualified Individual: a person who has been deemed eligible to enroll through the *FFM* in a *Qualified Health Plan* in the individual market.

Schedule of Benefits: the part of this *Policy* that outlines the specific coverage in effect. This includes the amount, if any, that you are responsible for paying towards your dental care.

Subscriber: the policyholder who has enrolled *covered dependents*. This is a child only policy, the subscriber has no coverage or benefits under the *Policy*. The *subscriber*. A parent or guardian enrolling a minor *dependent* assumes all of the *subscriber's* responsibilities on behalf of the minor *dependent*.

The Plan: refers to Dental Care Plus, Inc.

Utilization Review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

Utilization Review Organization means a person that conducts utilization external review, other than the health carrier performing a review for its own health plans.

Undue Delay means the lack of information sufficient to investigate and respond to the *grievance* within the time frame for a specific step in the process.

You: the *subscriber*.

Part II

Benefits

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

Class I

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

Benefits are available for the following *dental services* to diagnose or to prevent tooth decay and other forms of oral disease. Examples of these services include:

- Initial oral examination (including the initial dental history and charting of teeth); once per *dentist*.
- Periodic exam; 2 in 12 months.
- Panoramic x-ray; once every 60 months.
- Bitewing x-rays (x-rays of the crowns of the teeth); once every 12 months
- Single tooth x-rays; as needed.
- Oral and facial photographic images;
- Study models and casts used in planning treatment;
- Routine cleaning, scaling and polishing of teeth; 3 in 12 months.
- Fluoride treatment, Topical Fluoride - Varnish.
- Space maintainers required due to the premature loss of teeth
- Sealants on unrestored permanent molars, under age 16
- Diagnostic tests

Class II

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

Benefits are available for the following *dental services* to treat oral disease. Examples of these services include:

- Fillings consist of silver amalgam and in the case of front teeth, synthetic tooth color fillings. However, synthetic fillings are limited to single surface restorations for front teeth. Multi-surface synthetic restorations on front teeth are treated as an alternate benefit. The patient is responsible up to the *dentist's* charge.
- Sedative fillings.
- Stainless steel crowns
- Simple tooth extractions.
- General anesthesia. Only when necessary and appropriate for covered surgical services and only provided by a licensed, practicing *dentist*.
- Repair of dentures or fixed bridges. Recementing of fixed bridges.
- Rebase or reline dentures. Once every 36 months, 6 months after initial installation.
- Tissue conditioning.
- Repair or recement crowns and onlays.
- Adding teeth to existing partial or full dentures.
- Palliative (emergency) treatment of dental pain – minor procedures.
- Periodontal maintenance. 4 in 12 months, following active periodontal therapy.
- Consultation by a second dentist not providing treatment.

Class III

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

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

- Certain surgical services to treat oral disease or injury. This includes surgical tooth extractions and extractions of impacted teeth.
- Periodontal services to treat diseased gum tissue or bone. This includes the removal of diseased gum tissue (gingivectomy) and the removal or reshaping of diseased bone (osseous surgery). Periodontal benefits are based on our "Periodontal Guidelines."
    - Periodontal scaling and root planning; ever 24 moths – per quadrant

- Endodontic services for root canal treatment of permanent teeth. This includes anterior bicuspid and molar root canal, the treatment of the nerve of a tooth, the removal of dental pulp, and pulpal therapy. Vital pulpotomy is limited to deciduous teeth.
- Dentures and Bridges
    - Complete or partial dentures and fixed bridges. Includes services to measure, fit, and adjust them; once each 60 months.
    - Replacement of dentures and fixed bridges. Limited to non-serviceable and were inserted at least 60 months before replacement.
    - Maxillary dentures
- Crowns, Onlays and Inlays
    - Crowns, onlays and inlays, only when teeth cannot be restore with fillings due to severe decay or fracture, as follows:
        - Initial placement of crowns, onlays and inlays.
        - Replacement of crowns, onlays and inlays; once each 60 months per tooth.
- Porcelain, ceramic and cast metal retainers for resin bonded fixed prosthesis.

Part III

Limitations and Exclusions

1. BENEFITS ARE PROVIDED ONLY FOR NECESSARY AND APPROPRIATE *COVERED SERVICES*

We will not provide benefits for a *dental service* that is not covered under the terms of the *Policy*. We will not provide benefits for a *dental service* that is not necessary and appropriate to diagnose or to treat your dental condition.

A. To be necessary and appropriate, a *dental service* must be for the prevention of oral disease or with the diagnosis and treatment on teeth that are decayed or *fractured* or teeth where supporting periodontium is weakened by disease. The dental service must be also meet the standards of good dental practice and not solely for your convenience or the convenience of your *dentist*.

B. *The Plan* decides what is necessary and appropriate under the terms of the *Policy*. The *Plan* decides based on a review of dental records describing your condition and treatment. We may decide a service is not necessary and appropriate under the terms of the *Policy* even if your *dentist* has prescribed, ordered, recommended or approved the service.

2. *THE PLAN* DOES NOT PROVIDE BENEFITS FOR:

- Experimental procedures that have not been approved by The American Dental Association. Services that no procedure codes have been established.
- A *dental service* or procedure that is not described as a benefit in this *Policy*.
- Services that are rendered due to the requirements of a third party, such as an employer or school.
- Services that are covered by a health insurance policy or similar coverage in which you are enrolled.
- Travel, time, and related expenses.
- An illness or injury that is out of the course of your employment.
- A service that you are not required to pay, or that you would not be required to pay if you did not have coverage under this *Policy*.
- An illness, injury, or dental condition that benefits are received through a government program other than Medicaid or Medicare.
- A method of treatment more costly than is usually provided. Benefits are based on the least costly method of treatment.
- A separate fee for services rendered by interns, residents, fellows or *dentists* who are salaried employees of a hospital or other facility.
- Any charge related to an appointment with your *dentist* that you fail to keep.
- Dietary advice and instructions in dental hygiene. This includes proper methods of tooth brushing, the use of dental floss, plaque control programs and caries susceptibility tests.
- A service rendered by someone other than a *dentist* or a hygienist who is employed by a *dentist*.
- Prescription drugs.
- A service to treat disorders of the joints of the jaw (temporomandibular joints).
- A service, supply or procedure to increase the height of teeth (increase vertical dimension) or restore occlusion.
- Restorations for reasons other than decay or *fracture*, such as erosion, abrasion, or attrition.

- Services that are meant primarily to change or to improve your appearance.
- Repair or reline of an occlusal guard.
- Implants.
- Transplants.
- Replacement of dentures, bridges, space maintainers or periodontic appliances due to theft or loss.
- Services, supplies or appliances to stabilize teeth due to periodontal disease. An example is periodontal splinting.
- Lab exams.
- Laminate veneers.
- Duplicate dentures and bridges.
- Temporary, complete dentures and temporary fixed bridges or crowns.
- Cast restorations, copings and attachments for installing over dentures.
- Tooth desensitization.
- Occlusal guards and adjustment.
- Orthodontic services.
- Cosmetic dentistry
- Services performed outside of the United States.

Part IV

Effective Date, Enrollment and Disenrollment

1. WHEN YOUR COVERAGE BEGINS

The *covered services* described in this *Policy* are covered as of the *effective date* of the *Policy*, as set out in the *Schedule of Benefits*.

2. ENROLLMENT AND CONTRACT CHANGES

All enrollment applications and any additions or changes to the *Policy* are allowed ONLY when they conform to our Underwriting Guidelines. Coverage for a new spouse is effective from the date of marriage if notice and any required premium is submitted to us within 31 days. Coverage for newly born children is effective from the date of birth. Payment of any required premium must be submitted to us within 31 days to keep the *Policy* in force.

Newly adopted children are covered for an initial period of 31 days from either the date of placement for the purpose of adoption or the date of the entry of an order granting custody of the child for purposes of adoption, whichever comes first. Coverage will continue beyond 31 days if notice and payment of any required premium is provided before the expiration of the 31 day period. The date of placement for adoption is defined as the earlier of a judicial order of adoption or the assumption of custody, pending adoption of the child by an adoptive parent. This includes any child placed with you for adoption and any child for whom you are a party in a suit where adoption of the child is sought. A minor that guardianship is granted by court or testamentary appointment is covered from the date of appointment, if notice is provided in a timely basis. A child, who the court orders to be covered under a *subscriber's* dental coverage, is covered from the date of the order, if notice is provided on a timely basis. You are required to submit proof of the court order or relationship to *the Plan*.

3. ENROLLING *DEPENDENTS.*

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

A. Death of Spouse – If your spouse dies, you may add your dependent child(ren) to this *Policy* and without evidence of insurability if the dependent child(ren) previously were covered under your spouse's policy.

B. Court Order – If you are required under a court order to provide dental coverage for a child, the following rules apply:

1. You are allowed to enroll in *family coverage* and include the child in that coverage regardless of any enrollment period restrictions.

2. If you are enrolled but do not include the child in the enrollment, we will allow the noninsuring parent of the child, child support enforcement agency, or any other agency with authority over the welfare of the child to

apply for enrollment on behalf of the child.

3. You may not terminate coverage for the child unless written evidence is provided to us that the order is no longer in effect or that the child is enrolled under other reasonable dental coverage that will take effect on or before the effective date of termination.

4. ENROLLMENT THROUGH THE FEDERALLY FACILITATED MARKETPLACE AND PREMIUM PAYMENTS

If coverage is obtained through the *FFM*, the *FFM* will enroll *Qualified Individuals* and *dependents* based on the *FFM* requirements and applicable federal laws and regulations.

The Plan is required to process enrollments as outlined by the *FFM*. This requires *the Plan* to enroll a person when the *FFM* notifies *the Plan* that the person is a *Qualified Individual* or a *Qualified Individual's* dependent.

For coverage obtained through the *FFM*, premium payments are required to be made directly to *the Plan* by *the Plan's* available methods for payment. The first premium payment is due prior to the *effective date*, and premiums are due monthly thereafter.

A. Annual open enrollment periods.

1. Notice of annual open enrollment period. Starting in 2014, the *FFM* will provide a written annual open enrollment notice no earlier than the first day of the month before the annual open enrollment period begins and no later than the first day of the annual open enrollment period.

2. Effective date for coverage.
   a) If coverage is chosen between the 1st and the 15th of a month, your *effective date* for coverage is the first day of the following month.

   b) If coverage is chosen after the 15th of a month, your *effective date* for coverage is the first day of the second following month. (For example, coverage chosen on January 20th will have an *effective date* of March 1st).

3. First Month's Premium Payment. We must receive your first month's premium payment by no later than 30 days from the *effective date*.

B. Special enrollment periods.

1. Special enrollment periods. The *FFM* must allow *Qualified Individuals* and dependents to enroll in a *QHP* or change from one *QHP* to another as a result of the following triggering events:

   a) Loss of minimum essential coverage.

   b) Gaining or becoming a dependent through marriage, birth, adoption or placement for adoption.

c) Gaining status as a citizen, national, or lawfully present person.

d) Enrollment or non-enrollment was unintentional or accidental and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the *FFM* or the United States Department of Health and Human Services ("HHS"), or a non-*FMM* entity providing enrollment assistance or conducting enrollment assistance activities. This triggering event includes failure to comply with applicable federal standards, Federal Laws or State Laws.

e) Violation by *QHP* of a material section of its contract.

f) Newly eligible or ineligible for advance payments of the premium tax credit.

g) Relocation to a new service area of the *FFM*.

h) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a *QHP* or change from one *QHP* to another one time per month.

i) Proof that you or your *dependent* meets other exceptional circumstances as the *FFM* may approve.

2. Special enrollments are managed by *FFM*. For more information on special enrollment periods you should contact the *FFM* at 800-318-2596 or visit the *FFM* website at www.healthcare.gov.

3. Length of special enrollment periods. Unless specifically stated otherwise in the applicable *FFM* rules, a *Qualified Individual* or your *dependent* has 60 days from the date of a triggering event to choose a *QHP*.

4. Effective dates of coverage after a special enrollment period.

   a) Special effective dates.

      i. If you have a new *dependent* as a result of adoption, they are covered for an initial period of 31 days from the earlier of the date of placement for the purpose of adoption or the date of the order granting custody of the child. Coverage continues for your *dependent* beyond 31 days, if you notify the *FFM* within 60 days after the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting you custody of the child for purposes of adoption and we receive any required premiums.

      ii. If you have a new *dependent* as a result of birth, your new *dependent* will covered for an initial period of 31 days from the date of birth. Coverage will continue beyond 31 days if you

notify the *FFM* within 60 days after the date of the birth and we receive any required premiums.

ii. If you have a new d*ependent* as a result of marriage or your *dependent's* loss of minimum essential coverage, and you notify the *FFM* within 60 days of the date the event and we receive any required premiums. The *effective date* for your *dependent* is the first day of the month following the date of marriage or loss of minimum essential coverage.

5. WHEN YOUR COVERAGE ENDS

Coverage will terminate due to the following events:

A. The *subscriber* is no longer enrolled. In such circumstance, coverage for all *covered individuals* terminates.
B. A child under attains the age of 19

The last date of coverage is the last day of the month after the loss of eligibility. Benefits are provided based on the *Agreement* in effect at the time of termination. For a course of treatment for at least 90 days after the date coverage terminates if, the treatment begins before the date coverage terminates and requires two or more visits on separate days to a *dentist's* office.

6. TERMINATION OF POLICY

You may cancel this *Agreement* as set in this section.

1. Termination of coverage obtained through the *FFM*. The following termination rules apply when you cancel coverage obtained through the *FFM*.
    a. You must provide notice at least 14 days prior to the proposed effective date of termination. The last day of coverage is the termination date specified by you in the notice of termination. You can provide notice to the *FFM* either by calling at 1-800-318-2596 or www.healthcare.gov.
2. Termination of coverage not through the *FFM*. The following rules apply if coverage is obtained other than the *FFM*. You may cancel this *Agreement* for any reason. To do so, you must give us notice at least 30 days prior to the termination date.
3. This *Agreement* will renew or continue at your option. In compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191), renewability is guaranteed. The *Agreement* will remain active by timely payment of premiums. However, *the Plan* may cancel or refuse to renew this *Agreement* only for the reasons set forth in this section.
4. We may, upon 30 days' notice to you, cancel or refuse to renew this *Agreement* under any of the following circumstances:
    a. We may cancel this Agreement, subject to Contestability of Coverage set forth in Part V, Section 13. If you make any fraudulent claims or material misrepresentations to us or to any dentist we may cancel your *Policy*... This includes any incorrect or incomplete statements that led us to believe you were eligible for coverage when you were not. In this case, cancellation is as of your effective date. We will refund the premium you paid. We will subtract from the refund any payments made for claims under this Agreement. If we have paid

more for claims under this Agreement than you have paid us in premium, we have the right to collect the excess from you.

b. We may cancel this Agreement if you have not paid your premium, subject to Grace Period requirements under Part V, Section 15 of this Policy.
c. We may cancel this *Agreement* if we decide to withdraw this product from the individual market. In this case, you are offered a replacement policy.
d. We may cancel this *Agreement* if we withdraw entirely from the individual market.

5. Cancellation due to loss of eligibility
    a. This *Agreement* is canceled if you are no longer eligible. If you no longer reside in Michigan, the termination date is the last day of the month we were notified of your move and the premium has been paid.

Part V

Other Contract Provisions

1. BENEFIT PAYMENTS

IN-NETWORK SERVICES:

If a *covered individual* uses the services of a *contracting dentist*, the in-network benefit amount is based on the *fee schedule* that the *contracting dentist* has agreed to accept. When your *contracting dentist* provides *covered services*, they must accept the fee in the *fee schedule* as payment in full, except as provided under item 2 below. *The Plan* pays the *contracting dentist* directly for *covered services*.

OUT-OF-NETWORK SERVICES:

If a *covered individual* uses the services of a *non-contracting dentist*, the benefit for *covered services* is set forth in item 5 below.

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

In the following cases you are responsible for the difference between *the Plan* payment and the *dentist's* actual charge for *covered services*:

A. If you have received the maximum benefit allowed for *covered services* as stated in the *Schedule of Benefits*. For example, the maximum dollar amount for a *covered individual* in a calendar year, including the service that caused you to reach the maximum.
B. If you and your *dentist* decide to use services that are more expensive than those customarily used by most *dentists*. Benefits are provided based on the service with the lower fee.
C. If you receive payment from another person or an insurance company for injuries he or she caused.
D. If you receive services from more than one *dentist* for the same dental procedure. If you receive a series of services in a planned course of treatment. The total amount of benefit is not more than the amount that would have been provided if only one *dentist* had performed all the services.

3. PRE-TREATMENT ESTIMATES

Though not required, if your *dentist* expects that dental treatment involves a series of *covered services* (over $600), a copy of the treatment plan should be sent to *the Plan* BEFORE the services begin. A treatment plan is a detailed description of the procedures that the *dentist* plans to perform and an estimate of the charges for each service.

Upon receipt of the treatment plan, we will notify you and your *dentist* about the maximum benefits for the services reported. The pre-treatment estimate of benefits is valid for 90 days after the date we notify you, your covered *dependents* and the *dentist* of the benefits payable for the proposed treatment plan. If treatment is to begin more than 90 days after the date we notify

you, your covered *dependents* and the *dentist* of the benefits payable for the proposed treatment plan, you may submit a new treatment plan.

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

4. WHEN YOUR *CONTRACTING DENTIST* IS TERMINATED

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

If the *contracting dentist* cancels the *contracting dentist* agreement, for at least 90 days the *contracting dentist* will continue to provide *dental services* to *covered individuals* of *the Plan* for that the *contracting dentist* was responsible for prior to the notice of termination.

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

A. If you receive services from a *non-contracting dentist*, you may be required to pay more out of pocket than for services provided by a *contracting dentist*. Benefits for *covered services* provided by a *non-contracting dentist* are based on the lesser of the *dentist's* charge or the payment amount for services that a *contracting dentist* has agreed to accept in the *fee schedule* as payment in full. In addition, you are responsible for paying any difference between *the Plan's* payment to a *non-contracting dentist,* after any *deductible* or *coinsurance* amounts are calculated if the total charge exceeds the fee schedule amount for that *covered service.* The difference is based on the maximum allowable charge on the *fee schedule* and the *non-contracting dentist's* total charge. Benefits are payable based on the terms and conditions of the *Schedule of Benefits* in effect at the time services are rendered.

B. A *covered individual* may request a referral to a specialist who is a *non- contracting dentist* under the following instances. The *covered individual* is diagnosed with a condition or disease that requires specialized dental care, *the Plan* has not contracted with a specialist to treat the condition or disease and the specialist agrees to be reimbursed the same as a specialist that is a *contracting dentist.*
    a. To find out if your *dentist* participates with *the Plan* ask your *dentist* if he or she has an agreement with us, call our Customer Service department, visit our website, or check the directory of *contracting dentists*.

6. EMERGENCY CARE

All dental expenses for emergency care is paid as any other expense. Nothing in this *Policy* prohibits a *covered individual* from seeking emergency care whenever the person is confronted with an *emergency medical condition*. This includes the option of calling the local emergency medical services system by dialing 911, or its local equivalent. Emergency dental care is defined

in Part I. If you use the *dental services* of a *non-contracting dentist*, benefits are paid as the out-of-network benefits described in item 5 above.

7. SUBROGATION

A *covered individual* may have a legal right to recover some costs of his/her dental care from someone else because another person has caused his/her illness or injury. When they has this right, the *covered individual* must allow *the Plan* the right to recover any payments it has made for the illness or injury. If money is recovered from someone else, the *Plan* must be repaid for any payments made. *The Plan's* right to repayment comes first. The repayment amount is reduced only by *the Plan's* share of the cost to collect the claim against the other person. The *Plan* will not collect payment if the payment is for something other than a dental expense. The *covered individual* is obligated to provide *the Plan* with the written authorization, information and assistance to help *the Plan* recover its payment, and must not prohibit *the Plan* from collecting repayment.

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

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

Contracting dentists have agreed to give us all information necessary to process your claims under this *Policy* and have agreed not to charge for this service.

9. PREMIUM

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

The Plan will not adjust premiums or limit coverage based on genetic information. *The Plan* will not request, require or collect any genetic information from any person at any time for the purpose of underwriting

10. WE MAY CHANGE YOUR POLICY

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

11. REINSTATEMENT

A. Reinstatement of coverage obtained through the *FFM*. If any premium is not paid within the required time period and grace period stated in Part V, Section 24, this *Policy* and its coverage will lapse. You must contact the *FFM* for information on

reinstatement. You and your covered *dependents* are not eligible to re-enroll in coverage through the *FFM* until the next open enrollment period or qualification for a special enrollment period.

B. Reinstatement of coverage not obtained through the *FFM*. If any premium is not paid within the required time period grace period stated in Part V, Section 24, this *Policy* and its coverage will lapse. An acceptance of past due premium by us or an approved agent will reinstate the *Policy*. We may ask for a new application to accept your premium and reinstate your policy. If we require an application for reinstatement and issue a conditional receipt for the premium tendered, the *Policy* is reinstated upon approval of such application by us or, lacking such approval, upon the 45th day following the date of the conditional receipt unless we previously notified you in writing of our disapproval of the application.

If coverage is reinstated, *dental services* are only covered if received on or after the date of reinstatement. We, you, and your covered *dependents* have the same rights that existed under this *Policy* before the coverage lapsed, subject to any other requirements for reinstatement. We will apply the reinstated premiums to the period that the premium was not paid.

12. MISSTATEMENT OF AGE

If the age of the *subscriber*, or any covered *dependents,* has been misstated, there will be an adjustment of premium. The premium will be due for coverage of such person at the correct age and the amount of coverage will not be affected.

13. CONTESTABILITY OF COVERAGE

All statements, in the absence of fraud, made by you are representations and not warranties. No such statement will void the insurance or reduce benefits unless such false statement materially affected either the acceptance of the risk or hazard assumed by *the Plan.*

After this *Policy* has been in effect for 2 years, we will not use any material misstatements you may have made in your application, except any fraudulent misstatements, to void this *Policy* or deny a claim for any *covered services* incurred after the expiration of this 2 year period.

14. BENEFITS AFTER CANCELLATION

If this *Policy* is cancelled*,* no benefits are available for services you receive after the effective date of the cancellation, except as follows.

Benefits are provided for a course of treatment for 90 days after the date coverage terminates if the treatment began before the date coverage terminates and it requires two or more visits on separate days to a *dentist's* office.

15. GRACE PERIOD

A. General Grace Period

A grace period of 31 days is granted for payment of each premium payment due after the first premium payment. During the grace period, the *Agreement* will continue in force. If

premiums are not received before 31st day of the grace period, *the Agreement* will terminate as of the 31st day of the grace period.

B. Three Month Grace Period for a *Subscriber* Receiving Advance Payments of the Premium Tax Credit (APTC).

If a *subscriber* is receiving APTC and the *subscriber* has previously paid at least one full month's premium during the *Benefit Year*, the grace period is extended to 3 consecutive months.

During the 3 month grace period, *the Plan* will:

- Pay all claims for *covered services* rendered to the s*ubscriber* during the first month of the grace period. *The Plan* will pend claims for *covered services* rendered to the s*ubscriber* during the 2nd and 3rd months of the grace period.
- Notify HHS of the *subscriber's* non-payment of premium.
- Notify *dentists* of the possibility for denied claims for *covered services* when a s*ubscriber* is in the 2nd and 3rd months of the 3 month grace period.

During the 3 month grace period, *the* Plan will also continue to collect the APTC on behalf of the s*ubscriber*.

If the grace period is exhausted, *the Plan* will return the APTC that *the Plan* collected on behalf of the s*ubscriber* for the 2nd and 3rd months of the grace period.

16. NOTICES

A. To you: We will send notices and/or bills to you by first class mail. Once we mail the notice or bill we are not responsible for its delivery. This applies to a notice of a change in the premium or a change in the *Policy*. If your name or mailing address should change, you should notify *the Plan*. Be sure to give *the Plan* your old name and address as well as your new name and address.
B. To us: Send letters to Dental Care Plus, Inc., 10300 Springfield Pike, Cincinnati, OH 45215. Always include your name and *subscriber* identification number.

17. WHEN AND HOW BENEFITS ARE OBTAINED AND PROVIDED

This *Policy* is designed to provide high quality dental care and control the cost of care. To do this, this *Policy* encourages *covered individuals* to get dental care from *contracting dentists*, but, you are free to choose any *dentist.*

When the *covered individual* is enrolled and the first month's premium is received, a welcome packet which includes a dental plan identification card is sent.

Benefits are ONLY provided for *covered services* on or after the *effective date* of this *Policy*. If, before the *effective date*, you or a covered *dependent* started receiving services, NO BENEFITS are available for services related to that procedure.

In order for you to receive any of the benefits that you have a right, you must inform your *dentist* that you are a *covered individual* and supply any necessary information needed to file your claim. If you fail to inform your *dentist* within 12 months of receiving services, we are no longer required to provide any benefits for those services.

18. WE ARE NOT RESPONSIBLE FOR THE ACTS OF *DENTISTS*

We do not hinder with the relationship between *dentists* and patients. You are free to choose any *dentist*. It is your duty to find a *dentist*. We are not responsible if a *dentist* refuses to treat you. We are not responsible for injuries or damages caused by a *dentist*.

19. COORDINATION OF BENEFITS

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

The below 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 based on 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.

If the plans cannot agree on the order of the benefits within 30 calendar days after the plans have received all of the information needed to pay the claim, the plans will immediately pay the claim in equal shares. A plan is not required to pay more than it would have paid had the plan had been the primary plan.

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 and subscriber contracts; health insuring corporation ("HIC") contracts; uninsured arrangements of group or group-type coverage; group or nongroup coverage through closed panel plans; medical care components of long-term care contracts, such as skilled nursing care; medical benefits in automobile "no fault" and traditional automobile "fault" type 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; limited benefit health coverage; school accident type coverage covering grammar, high school, and college students for accidents only; benefits for non-medical components of long-term care policies; benefits in long-term policies that pay a fixed daily benefit without regard to expenses incurred or the receipt of service in long-term care policies; Medicare

supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

3. "Health care coverage" includes coverage for *dental services*.

4. "Health care services" includes *dental services*.

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, the part of the contract providing health care benefits to which the COB 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 to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB to coordinate other benefits.

C. The order of benefit decision rules decide if 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 pays for benefits any other plan without regard to any other plan's benefits. When this Plan is secondary, it pays benefits after the primary plan. It 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 is 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 due to a contractual agreement is prohibited from charging a covered person is not an allowable expense.

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

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

2. If a Subscriber is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees, 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 a plan that calculates its benefits or services on the basis of usual and customary fees, relative value schedule reimbursement, or another similar reimbursement, and another plan that provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is considered 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 the negotiated fee or payment is the secondary plan's allowable expense.

5. Any primary plan's benefit reduction because a covered person has failed to comply with the plan requirements 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. It 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 of a child for more than one-half of the calendar year by a court order or, in the absence of a court order, 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. Except as detailed below, a plan that does not contain coordination of benefits requirements that is consistent with this provision is always primary unless both plans state that the complying plan is primary.

Coverage that is obtained as a member of a group that is designed to supplement a basic package of benefits is in 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 applied to the base plan hospital and surgical benefits, and 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 decides 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 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 other than as dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed. 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 order stating otherwise, when a dependent child is covered by more than one plan the order of benefits is decided as follows:

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

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

        ii. If both parents have the same birthday, the plan that has covered the parent the longest is the primary 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 order 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. If the parent with the responsibility has no health care coverage for the dependent child, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule does not apply with respect to any claim decision period or plan year during which any benefits are actually paid or provided before the plan has actual knowledge of the terms of the court order;

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

        iii. If a court order 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 details of Subparagraph (a) above determines the order of benefits; or

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

(1) The plan covering the custodial parent.

(2) The plan covering the spouse of the custodial parent.

(3) The plan covering the non-custodial parent.

(4) 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 details of Subparagraph (a) or (b) above will determine the order of benefits as if those people were the parents of the child.

3. Active, retired, or laid-off employee. The plan that covers a person as an active employee, meaning, 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 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 decide the order of benefits.

4. COBRA or state 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 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 decide 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. The plan that covered the person the shorter period of time is the secondary plan.

6. If the above rules do not determine the order of benefits, the allowable expense is shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it was the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this Plan is secondary, it may reduce its benefits. The total benefits paid from all plans is not more than the total allowable expense. In determining the amount to pay for any claim, the secondary plan will calculate the benefits it would pay in the absence of other health care coverage. Then they will apply that calculated amount to any allowable expense that is unpaid by the primary plan. The secondary plan may reduce the payment so that, when combined with the amount already paid, the total benefits paid for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit 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 will not apply between that plan and other closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about coverage and services are needed to apply these COB rules and to decide benefits under this Plan and other plans. Michigan DentaTrust may get the facts it needs from or give them to other organizations/persons for the purpose of applying these rules. Michigan DentaTrust 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 pay benefits.

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 the 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, it may recover the excess from any other person or organization that may be responsible for the benefits or services for the covered person. The "amount of the payments made" includes the 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 1-800-436-5298. If you are still not satisfied, you may call the Michigan Department of Insurance for instructions on filing a consumer complaint. Call (877)-999-6442, or visit the Department's website at https://difs.state.mi.us/Complaints/

RIGHT TO RECOVER OVERPAYMENTS

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

IMPORTANT: No statement in this section should be interpreted to mean that we will provide any more benefits than those already described in the Benefits Section of this *Policy*. Remember that under COB, the total of the payments made for *covered services* will not be more than the total of the allowed charges for those *covered services*. We will not provide duplicate benefits for the same services. If you have any questions about COB and your *Policy*, please contact our Customer Service department at 1-800-436-5298.

20. CHOICE OF LAW

This *Policy* is written according to the laws of the State of Michigan. Any details in this policy that, on its effective date, are in conflict with the statutes of the state of Michigan is hereby amended to conform to the minimum requirements of such statutes.

21. PHYSICAL EXAMS AND AUTOPSY

We reserve the right to examine you while a claim is pending or while a dispute over a claim is pending. These exams are made at our expense and as often as we may require. We also have the right to an autopsy if the law does not prohibit it.

22. LEGAL ACTIONS

No legal action will be brought to recover under this *Agreement* prior to 60 days after a claim has been presented to us. No such action will be brought unless brought within 3 years from the expiration of the time within such claim submission is required.

23. CHANGE OF BENEFICIARY

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

24. REFUND OF PREMIUM

In the event of your death, the amount of premium refund is prorated from the date following the date of your death to the end of the *benefit period* that the premium has been paid. If someone other than you paid the premium, the refund is paid to that person upon proof of payment. If you paid the premium, the refund is paid to your surviving spouse. If there is no surviving spouse, the premium is paid in the same manner as distribution of a person who dies without a will under Michigan law.

25. ENTIRE AGREEMENT; CHANGES

This *Policy*, including the attached *Schedule of Benefits*, the application, and any applicable riders, endorsements and supplemental agreements creates the entire agreement between the parties. No change in this *Policy* are valid until approved by an executive officer of *the Plan*. No agent has any authority to change this *Policy*.

26. COMPLAINT AND GRIEVANCE PROCEDURES

NOTE: *The Plan*, as used in these *complaint and grievance* procedures will mean Dental Care Plus, Inc. c/o DentaQuest, LLC, P.O. Box 2906, Milwaukee, WI 53201. *The Plan* has delegated its internal *grievance* process to DentaQuest.

A. Complaint Procedures

The Plan has a responsibility to provide *covered individuals* with ample methods to make inquiries and express concerns about *the Plan*. The following process has been set up to assure that the *covered individual* will receive a response to any *complaint* and formal redress if appropriate.

A *complaint* is filed by contacting the Customer Service Department of *Plan*. The *covered individual* may contact Customer Service in writing, by telephone or by email. Customer Service will attempt to resolve the *complaint* through informal discussions, consultations, or conferences, and will notify the *covered individual* of its decision within 10 working days following receipt of the *complaint*.

If your *complaint* involves a decision by *The Plan* to deny, reduce or terminate benefits, you also have the right to file a *grievance*. Although you are not required to file a *complaint* before appealing a decision by *The Plan*, you are encouraged to. Some issues may be quickly resolved without the need for an *appeal*. You or your covered dependents have the right to file a *grievance* requesting that we formally review our benefit decision, as provided under the *"Internal Formal Grievance Procedure"* section.

B. Internal Formal Grievance Procedure

Filing a Grievance

A *grievance* must be filed within 180 days from the date of discovery of the potential *grievance*. In order to file a *grievance*, send a letter to:

Dental Director,
Complaints and Grievances Department,
Michigan DentaTrust Dental Plan
c/o DentaQuest, LLC
P.O. Box 2906, Milwaukee, WI 53201

When we receive the *grievance* from a *covered individual*, we will investigate the complaint and provide timely written notices, in plain English, of our progress of the investigation. Upon completion of our investigation of the *grievance,* we will give the *covered individual* written notice, in plain English that will provide:

1. The results of our investigation; and

2. Advisement of the *covered individual's* right to have the *grievance* reviewed by:

   a. The DIFS *Director*; or

b. A *utilization review organization* under the Patient's Right to Independent Review Act.

Mail:

Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
P.O. Box 30220
Lansing, MI 48909-7720

Delivery service:

Office of General Counsel - Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan St., 7th Floor
Lansing, MI 48933-1521
https://difs.state.mi.us/Complaints/ExternalReview.aspx (online portal)

DIFS-HealthAppeal@michigan.gov. (email)

Toll Free Telephone: 877-999-6442
FAX: 517-284-8838 *Adverse Benefit Determinations*

If we give *an adverse benefit determination* to a *covered individual*, it is sent in writing and contain the reasons for the *adverse benefit determination*. We will also provide the *covered individual* with any written notices required under the Patient's Right to Independent Review Act. Upon receipt of the *adverse benefit determination*, the *covered individual* or an *authorized representative*, may file a written *grievance* requesting further review by contacting:

Dental Director,
Complaints and Grievances Department,
Michigan DentaTrust Dental Plan
c/o DentaQuest, LLC
P.O. Box 2906, Milwaukee, WI 53201

The request should include the following information:

1. Sufficient documentation for us to appropriately investigate the *grievance*;
2. The providers' response; and
3. Your name, Social Security Number, address, and phone number, and the name and Social Security Number of the covered dependent, if applicable. This information is to be provided in all communications with us.

We may also request a second opinion at our own expense.

Time Period to Complete *Grievance* Review

We will complete our review of the *grievance* and make a final decision in writing to the *covered individual* not later than thirty-five (35) calendar days after the written *grievance* is submitted to us. The 35-day period may be extended by ten (10) business days if we have not received requested information from a health care facility or health professional.

Process for Internal Formal Grievance Procedures

The following are the actions that are taken in the *grievance* procedure process. All actions are complete within the required 35-day period.

1. **Initial Review of a *Grievance*:** When the *covered individual* has been advised by us of an adverse determination, the *covered individual* or an *authorized representative*, may appeal to our Complaints and Grievances Department ("C&G Department"). When we receive the *grievance*, it is logged in our records, and C&G Department will contact you by telephone.

    a. The C&G Department will contact the dentist or the dentist's staff regarding the complaint or inquiry.

    b. The C&G Department will fully investigate the *grievance* and provide a written initial decision to the *covered individual*. The written decision will specify the reasons for the decision. If the *covered individual* receives an adverse determination, he or she may make an appeal as detailed in subparagraph number 2, indicated below in this section.

    c. The *covered individual* or an *authorized representative* may request or agree to a delay in the resolution of the *grievance*. In the event a delay is agreed upon, the C&G Department will notify the *covered individual*, or an *authorized representative*, in writing of any delay and the reason(s) for such delay.

2. **Further Review of a *Grievance*:** If a *grievance* is not resolved as provided in provision number 1, Initial Review of a *Grievance*, the covered individual or an *authorized representative* may request further review either orally *or* in writing to Dental Director at P.O. Box 2906, Milwaukee, WI 53201. Our Dental Director will meet with the C&G Department staff and setup a meeting to discuss the *grievance* with the covered individual or *authorized representative*. The *covered individual* is notified by telephone or in writing of the time, date and location of the meeting. The notice will advise that the covered individual may be physically present, present via telephone, present with legal counsel, represented by legal counsel, or the covered person's *authorized representative* at the meeting to present *evidence* on behalf of the *covered individual*. The written notice is issued timely and written in plain English.

    Our Dental Director will inform the *covered individual* or an *authorized representative*, in writing, of the covered individual's right to a review of the matter by: the Director or a designee; or an independent review by an independent review organization under the Patient's Right to Independent Review Act (*PRIRA*).

    a. We may waive our internal *grievance* process and the requirement for a *covered individual* to exhaust the process before filing a request for an external review or an expedited external review.

b. The *covered individual* is considered to have exhausted our internal *grievance* procedures if we have failed to comply with the requirements of the internal *grievance* process unless the failure or failures are based on de minimis violations that do not cause, and are not likely to cause, prejudice, or harm to the covered person.

3. **External Review:** The *covered individual* or an *authorized representative* may request an external review as allowed by The Patient's Right to Independent Review Act. However, a request for an external review of an adverse determination must not be made until the *covered individual* has exhausted Our Internal Grievance Procedures, unless the covered individual has requested an expedited grievance.

   The Dental Director will render a decision for all parties. No later than one-hundred twenty-seven (127) days after the date of receipt of the Dental Director's determination or *final adverse determination* from us, the *covered individual* or an *authorized representative* may seek review with the Director. The *covered individual* or your *authorized representative* must submit a Request for External Review online (https://difs.state.mi.us/Complaints/ExternalReview.aspx) or with the paper form. The request should include a copy of the *final adverse determination* and documentation to support your position.

4. ***Expedited Grievance***: The covered individual has ten (10) days to request an expedited external review with DIFS. To obtain information regarding the external review or to file a grievance with DIFS, the *covered individual* or an *authorized representative* should contact Dental Director who will assist with filing the appropriate request for an external review within seventy-two (72) hours of receiving the request.

   It is the responsibility of the covered individual or an *authorized representative* to notify us of:

   (a) the nature of the *grievance*;

   (b) the names and dates of the parties involved with the *grievance,* i.e., the name of the facility; the Dentist involved; (any known witnesses, and if known their job title or function; the facts of the claim and any other facts that the *covered individual* believes are important so that the grievance can be resolved in an expedited manner.

   DIFS will notify the *Plan*, the *covered individual* and, if applicable, the *authorized representative* in writing within 2 days of completing the review of the decision to either uphold or reverse the adverse determination or final determination.

   Within two (2) business days after receipt of the DIFS decision, we will provide the *covered individual* or an *authorized representative* a written response. The notice is issued timely and written in plain English.

Annual Reporting Requirements

We will keep summary data on the number and types of *complaints* and *grievances* filed with us. Each year, by April 15th, summary data for the prior calendar year will be filed with the DIFS Director on forms provided by the Director.

Records

We will keep a complete file of all *grievances* and responses for two (2) years. They are available for inspection by DIFS and other regulatory agencies.

27. CONVERSION

Under the situations below, *covered individuals* have the option to convert to another dental plan that *the* Plan offers. Upon receipt of a written application and payment of the first month's premium not later than 31 days after the termination of coverage under this *Policy*, *the Plan* will issue a converted policy.

The option for conversion is available to the following people:

- Upon the death of the *subscriber*, to the surviving spouse and any *dependents* that are covered under the *Policy*;
- To a child solely with respect to the child upon attaining the limiting age of 19.

Part VI

Filing a Claim

1. EXPLANATION OF BENEFITS (EOB)

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

2. WHO FILES A CLAIM

Contracting Dentists: *Contracting dentists* will file claims directly with us for the services covered by this *Policy*.

Non-Contracting Dentists: *Non-contracting dentists* may file claims directly with us or you may need to submit claims.

3. NOTICE OF CLAIM

Written notice of claim must be sent to us within twenty (20) days after any loss for *covered services*, or as soon thereafter as is reasonably possible. Notice should be given to us at Michigan DentaTrust Dental Plan, c/o DentaQuest, LLC, P.O. Box 2906, Milwaukee, WI 53201, or to any agent approved by us, with information sufficient to identify you.

4. CLAIM FORMS

Upon receipt of a notice of a claim, we will send you with forms for filing proofs of loss. If forms are not sent within fifteen (15) days after the receipt of notice, you are considered to have complied with the requirements. This *Policy* requires submission within the time required, written proof covering the occurrence, and the extent of the loss the claim has made.

5. PROOFS OF LOSS

Written proof of loss is sent to Michigan DentaTrust Dental Plan, c/o DentaQuest, LLC, P.O. Box 2906, Milwaukee, WI 53201. In the case of claim for loss that the *Policy* provides any periodic payment that are subject to continued loss must be sent within 90 days. In the case of a claim for any other loss, the claim must be submitted within 90 days after the date of loss. Failure to send proof of loss within the time required will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time. In no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

If you have any questions, contact our Customer Service department.

1-800-436-5298

6. TIME OF PAYMENT OF CLAIMS

After we receive your complete forms, we will send notice of a processed claim. Notice is sent no later than 30 days for a claim filed electronically or 45 days for a claim filed on paper. Notice is either payment for your claim to the extent of your benefits under this *Policy*, notice of why we are not paying your claim, or notice the claim is in dispute. If your claim is in dispute, additional information might be necessary to decide if all or part of the claim will be reimbursed. If additional information is necessary, you will be notified what specific additional information is needed. Upon receipt of the requested information, we will process the claim within 15 days. If we fail to respond within these time periods, we are responsible for interest only as required by Michigan law. If you have any questions, contact our Customer Service Department at 800-436-5298..

7. PAYMENT OF CLAIMS

Any amounts due for *covered services* at the time of your death are paid to the designated beneficiary or to the estate.

Part VII

Index

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

SCHEDULE OF BENEFITS

Michigan DentaTrust , Individual Dental Plan
Child Only Coverage Low Option
(underwritten by Dental Care Plus, Inc.)

To be attached to and form a part of the Dental Care Plus, Inc. (*the Plan*), *Policy* for Michigan DentaTrust Dental Plan coverage.

The *subscriber* has purchased this coverage for the period beginning January 1, 2024, 12:00 AM through December 31, 2024, 11:59 PM, Eastern Time. The monthly premium referred to in the *Policy* is:

One Child Rate: $15.99 per month
Two or More Children Rate: 26.39 per month

The *Policy,* including this *Schedule of Benefits,* refers to various dollar and percentage amounts, as well as other benefit information that may be specific to the *covered individual*. *The Plan* does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan. You should read your *Policy* carefully.

NOTE: The *Policy* only covers children until the last day of the month in which they obtain the age of age 19. There is no coverage under the *Policy* for any person age 19 or older. Further information on eligibility is set forth in the *Policy*.

Benefits for *covered services* described in the *Policy* are reimbursed as follows:

Policy Number:	XXXXXX
Subscriber:	John Doe
Subscriber Address:	123 Main Street, Anytown, XX XXXXX
Dependent[s]:	Jane Doe

SCHEDULE

Coverage Type	**Deductible In-Network**	**Plan Pays In-Network**	**Deductible Out-of-Network**	**Plan Pays Out-of-Network**
Class I - **Diagnostic & Preventive Services**	Per covered individual: $10.00 *copayment* on routine exams and prophylaxis per visit	100%	Per covered individual: $10.00 *copayment* on routine exams and prophylaxis per visit	100%
Class II - **Restorative and Other Basic Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy:* $150	50%
Class III - **Complex Dental Services**	Per covered individual: $50 Per *Policy:* $150	50%	Per covered individual: $50 Per *Policy*: $150	50%

NOTE: *Non-contracting dentist's* are permitted to charge for the difference between the *fee schedule* and *non-contracting dentist's* billed charges. You may be required to pay more for services obtained from *non-contracting dentist* than the same services provided by *a contracting dentist.*

SERVICES FOR COVERED INDIVIDUALS UNDER AGE 19

A *covered individual* is considered to be under age 19 until the last day of the month in which the *covered individual* obtains the age of 19.

DEDUCTIBLES

Restorative and other Basic Services, and Complex Dental Services described above are subject to a *deductible* for each *covered individual* in each contract.

OUT OF POCKET MAXIMUM

The *out of pocket maximum* related to in-network *covered services* is limited to $400 per *Policy* with one *covered individual* under age 19 and $800 per *Policy* with two or more *covered individuals* under age 19.

ANNUAL LIMITS and MAXIMUMS

There are no annual limits or maximums on our payment for in-network *covered services*.

WAITING PERIOD

Diagnostic and Preventive Services, Restorative and other Basic Services, and Complex Dental Services are not subject to waiting periods.

NOTE: Italicized terms are defined in the *Policy*.

If you have questions about this coverage, please contact our Account Service Department at [1-855-343-4263].