

## Schedule of Benefits

**Benefit Plan Number:** D910

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

**Annual Maximum Benefit:** \$1000 per Member

**Orthodontic Lifetime Maximum Benefit:** \$0 per Eligible Member

**Deductible:** \$50 per Member, per Benefit Year  
 \$150 per Family, per Benefit Year  
 The deductible applies to Basic and Major Benefits only

Covered Dental Services	Deductible Applied	Percentage of Allowable Expense Paid by the Plan	Member Copayment
Preventive Benefits	No	100%	None
Basic Benefits	Yes	50%	50%
Major Benefits	Yes	50%	50%

**Additional Covered Dental Services and Limitations:**

Implant Services are covered as Major Benefits as follows:

Implants..... Limited to one original or replacement implant every five years (per tooth).

Implant abutments..... Limited to one original or replacement implant abutment every five years (per tooth).

Implant and abutment..... Limited to one original or replacement prosthesis every five years (per tooth).  
 supported crowns,  
 bridges and dentures

Implants in replacement of natural teeth which were extracted while the Member was not covered under the Plan are excluded from coverage.



## **MEMBER HANDBOOK**

**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.**

# **MEMBER HANDBOOK**

## **WELCOME TO DENTAL CARE PLUS**

We have prepared this booklet to help you understand how to use your Dental Care Plus coverage. Please read it carefully and keep it handy for future reference.

### **WHAT IS DENTAL CARE PLUS?**

Dental Care Plus (DCP) is an organized system of dental care providing a broad range of services for a prepaid monthly premium. This program is unique, as it combines the high quality of conventional dental insurance with the benefits and efficiency of an IPA (Independent Practice Association).

We believe that through preventive care and early detection, serious dental problems can be avoided. Preventive dental care performed by a dental professional is more than just a check for cavities. Many physical conditions, from vitamin deficiencies to cancer, can be detected through oral examination. Benefits are usually paid in full or the copayment is small for these services to encourage regular dental visits.

We strongly advise our Members to see a DCP dentist twice a year for this thorough check up which is an essential part of their total health.

### **1800 DENTISTS TO CHOOSE FROM**

There are approximately 1800 dentists who are Participating Dentists in this unique dental plan. Except for out of area emergencies, you are required to receive dental services from a Participating Dentist. Chances are your dentist is already a Participating Dentist.

### **EASE OF USE**

When you join DCP, claim forms are eliminated. Your Participating Dentist will work directly with us. When you obtain dental services, just show your DCP identification card. Your dentist will file a claim for you.

### **VALUE FOR YOUR MONEY**

DCP makes high quality dental care affordable. Out-of-pocket expenses are minimized. With DCP, Participating Dentists limit their fees for DCP patients. DCP and your Participating Dentist are committed to providing the best in dental care.

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# CERTIFICATE OF COVERAGE

(under a Master Group Contract)

Issued by

DENTAL CARE PLUS, INC.

100 Crowne Point Place

Cincinnati, Ohio 45241

## INTRODUCTION

Dental Care Plus (DCP) hereby certifies that you and any family members named on the DCP Identification Card(s) for whom the required prepaid Dental Premium has been paid, are entitled to coverage under the Master Group Contract (referred to in this Certificate of Coverage as the "Contract") provided you meet the eligibility requirements stated in the Contract.

The coverage you are entitled to under the Contract is referred to in this Certificate of Coverage ("Certificate") as the Plan. Coverage under your Plan is subject to the exclusions, limitations, conditions and other terms of the Master Group Contract. As a Certificate, this document summarizes the terms of coverage under your Plan but does not constitute the Contract. Certain terms of coverage summarized below may be modified by Amendments to this 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 any Amendments and the Schedule of Benefits carefully. You may examine the Contract at the offices of your Enrolling Unit during regular business hours.

## DEFINITIONS

***Allowable Expense*** is any necessary expense covered in full or in part under your DCP Plan.

***Annual Maximum Benefit*** is the maximum amount DCP will pay under your Plan for Covered Dental Services received by a Member in a Benefit Year.

***Benefit Year*** means the 12 month period for which benefits under the Plan 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 Plan. 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 Participating Dentist. See the Schedule of Benefits for Copayment levels.

***Covered Dental Services*** are services which are covered under the Plan and for which DCP will pay all or part of the Allowable Expense. Covered Dental Services are described in the Covered Dental Services section of this Certificate and the Schedule of Benefits.

***Deductible*** is the amount which the Member is required to pay for Covered Dental Services before benefits are paid by DCP under the Plan.

***Dental Premium*** means the amount which is payable by the Employer and/or the Subscriber for coverage under the Plan.

***Enrolling Unit*** means the employer or other entity with whom the Contract is made.

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

***Lifetime Maximum Benefit*** is the maximum amount DCP will pay under your Plan for Covered Dental Services received by a Member during the Member's lifetime.

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

***Participating Dentist*** means any dentist who has entered into an agreement with DCP to provide Covered Dental Services to Members.

***Subscriber*** means any employee, eligible by virtue of employment and proper enrollment, to receive Covered Dental Services provided under the Plan.



## **ELIGIBILITY INFORMATION**

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

Under the Plan, 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. If the child resides outside of the DCP service area, evidence of the Qualified Medical Child Support Order will be required.
  - Legally adopted child(ren), foster child(ren), or child(ren) for which you have legal custody.
  - Child(ren) who have been placed with you for adoption, if legal adoption is anticipated but not yet finalized, as defined in the Ohio Revised Code 3924.51(A)(3). For further details please contact DCP.
  - 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 DCP.

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. The Dependent Child must be primarily dependent on the Subscriber for support and maintenance. Evidence of full-time student status must be furnished annually to DCP or more frequently as requested. In addition, a Dependent Child age 19 - 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 Plan as a Dependent Child; or
- The end of the month in which they are no longer enrolled as full-time students.

Note: All Dependent Children, as defined above, should also be eligible to be claimed as a dependent for the purposes of the Internal Revenue Service, and principally reside with the Subscriber. Enrollment, however, shall not be denied if the Internal Revenue Service and/or residency conditions are not satisfied.

In no event shall the term Family Dependent include (a) a spouse or child on active duty in any military service of any country, (b) a child who is eligible for coverage under the Plan as a Subscriber.

## **ENROLLMENT AND EFFECTIVE DATE OF INDIVIDUAL COVERAGE**

### ***Enrollment***

An eligible Employee may enroll himself and any Family Dependent during the initial eligibility period by filing an application provided by DCP. A newly acquired Family Dependent is eligible to enroll in the Plan for a period of thirty-one (31) days beginning on the date he becomes a Family Dependent.

The Enrolling Unit shall notify DCP 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 Contract takes effect, or as otherwise specified in the Enrolling Unit's application.

Unless otherwise provided by the Contract, a Subscriber not actively at work (except while on paid vacation or unpaid leave under FMLA) on the date the Contract 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 this Contract until the Subscriber's coverage becomes effective.

### ***Changes in Plan Coverage***

You can change your level of coverage before the next annual enrollment period 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 DCP within 31-days\* of your change in family status. DCP reserves the right to require the applicant 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

\*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 Depend 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.

## IDENTIFICATION CARD

You will be issued Identification Card(s) which will list the names of all enrolled Family Dependents. 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 DCP.

## DENTAL SERVICE AREA

For Ohio and Indiana residents, you and your eligible Family Dependents must reside within the service area. For Kentucky residents, you and your eligible Family Dependents must reside within a fifty (50) mile radius of the service area. The following are the counties currently within the DCP service area:

<b>Ohio Counties</b>	<b>Kentucky Counties</b>	<b>Indiana Counties</b>	
Adams	Anderson	Jessamine	Decatur
Brown	Bath	Kenton	Dearborn
Butler	Boone	Lewis	Fayette
Clark	Bourbon	Madison	Franklin
Clermont	Bracken	Mason	Jefferson
Clinton	Bullitt	Meade	Jennings
Darke	Campbell	Mercer	Ripley
Fayette	Carroll	Montgomery	Switzerland
Greene	Clark	Nelson	Ohio
Hamilton	Fayette	Nichols	Union
Highland	Fleming	Oldham	
Miami	Franklin	Owen	
Montgomery	Gallatin	Pendleton	
Preble	Garrard	Robertson	
Warren	Grant	Scott	
	Hardin	Shelby	
	Harrison	Spencer	
	Henry	Trimble	
	Jefferson	Woodford	

## PARTICIPATING DENTISTS

DCP Members must seek service from a Participating Dentist. In most cases, Members can retain their own dentist since all licensed dentists in the Service Area are eligible to participate in DCP, and most do participate. Please refer to the Participating Dentist Directory provided to you with your enrollment materials for an alphabetical listing of DCP Participating Dentists. Or, to access the most current listing of Participating Dentists, please visit our website at [www.dentalcareplus.com](http://www.dentalcareplus.com).

## **NON-PARTICIPATING DENTISTS**

DCP Members seeking service from a Non-Participating Dentist will be responsible for the full payment to the dentist for dental services which would otherwise have been covered under the Plan, unless Prior Plan Approval has been obtained from DCP. Prior Plan Approval may or may not be granted by DCP based upon the circumstances of each individual situation. The decision to grant or deny Prior Plan Approval is final and is at the sole discretion of DCP.

### **EMERGENCY CARE WITHIN THE SERVICE AREA**

Emergency Care within the service area is available through Participating Dentists. In emergency situations, such as relief of pain, bleeding, swelling, or other acute conditions, the Participating Dentist will provide the appropriate services and schedule an appointment for follow-up care.

### **EMERGENCY COVERAGE OUTSIDE SERVICE AREA**

If emergency dental treatment is provided to a Member by a Non-Participating Dentist when the Member is 50 miles or more away from the service area, the Member must submit to DCP a statement of services provided for approval and payment determination. Emergency treatment outside the service area by a Non-Participating Provider is limited to relief of pain, bleeding, swelling, or other acute conditions.

### **COPAYMENT AND MAXIMUM BENEFITS**

Copayments are amounts that are directly payable by a Member to the dentist for Covered Dental Services. Participating Dentists must seek compensation solely from DCP, except for Copayments and Deductibles, for all Covered Dental Services. Your Plan may also have an Annual or Lifetime Maximum Benefit level, after which no benefits are paid by DCP. See the Schedule of Benefits for Copayment and Annual and Lifetime Maximum Benefit levels.

### **DEDUCTIBLE PROVISION**

Your Deductible is per Covered Member, per Benefit Year. The Deductible amount is identified in the Schedule of Benefits.

After you pay the Deductible, your DCP coverage pays a portion of the remaining Allowable Expenses up to the specified maximum(s). You pay for the balance, 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 OF NON-COVERED SERVICES**

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

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

## **ALTERNATIVE BENEFIT POLICY**

Many dental conditions can be treated in more than one way. This Plan has an “alternative benefit policy” which governs the amount of benefits DCP will pay for treatments covered under the Plan. If two or more alternative treatments are both covered under the Plan, 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 which provides professionally satisfactory results at the most cost-effective level. The Member will pay the difference in cost.

# COVERED DENTAL SERVICES

All payments made by DCP under the Plan for Preventive, Basic, and Major services will apply to the individual Annual Maximum Benefit referenced in the Schedule of Benefits. The following is a list of dental services which are typically covered under DCP Plans. The dental services listed below are covered under your Plan unless the Schedule of Benefits or an Amendment to this Certificate indicates the services are excluded or limited.

**NOTE:** *Some of the dental services listed in this section may not be covered under your Plan, 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 your Plan.*

## PREVENTIVE BENEFITS

### *Preventive & Diagnostic Services*

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
Entire dental series..... (at least 14 films)	limited to once every three years
OR	
Panoramic survey (single film).....	limited to once every three years

## BASIC BENEFITS

### *Emergency Services*

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*

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

*Space Maintainers*

Fixed band type ..... only under a treatment plan filed with DCP. Limited to children under age 19.

*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..... 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.

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 prophylaxis..... limited to two each year following a history of periodontal disease.

*Endodontic Services (Includes local anesthesia and routine postoperative care)*

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.)*

Restorations  
 (amalgam, composite and sedative fillings)..... 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 your Plan. Please refer to the Schedule of Benefits to determine whether Orthodontic Benefits are covered under your Plan.**

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

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 by your dentist to DCP. The dentist providing this service must supply DCP with films and study models upon request.

DCP will make an Initial Payment of benefits, based on the schedule 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 first Member payment for the Initial Charge will be at the discretion of the Orthodontist. Under the Plan, up to 25% of the total treatment cost may be recognized as the Initial Charge, of which DCP's 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 DCP's benefit program, DCP will deduct the payments made by the other company's benefit program(s) from the DCP Lifetime Maximum Benefit. All benefits paid toward orthodontic services by all previous benefit programs will be applied to the DCP Lifetime Maximum Benefit.

All limitations can be appealed to DCP.

## EXCLUSIONS

The following are services specifically excluded from coverage under the Plan. The Member is financially obligated for payment to the dentist of the full charge for any service that is excluded/not covered under the Plan.

1. Services performed by a Non-Participating Dentist, except for emergencies outside of the service area, unless Prior Plan Approval has been obtained from DCP.
2. 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.
3. Services or supplies which are considered experimental according to standard dental practice.
4. Charges which are incurred before the Member's effective date of coverage or after the date a Member's coverage terminates.
5. Services or procedures started prior to the effective date of the Member's coverage, with the exception of orthodontic services if covered by the Contract. 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 this Certificate or the Schedule of Benefits.
6. 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 Plan.
7. Porcelain coverage on posterior crowns.
8. Missed appointment charge.
9. Completion of claim forms.
10. Replacement of lost, stolen, or broken prosthetic devices unless it is after the limitation date.
11. Analgesics, nitrous oxide, non-intravenous conscious sedation and other drugs and prescriptions.
12. Localized delivery of antimicrobial or chemotherapeutic agents.
13. Hospital related charges.
14. Appliances, restorations, and procedures other than full dentures, for the primary purpose of increasing vertical dimension, restoring the occlusion or treatment of Bruxism.
15. Veneers or similar properties of crowns and pontics.

16. Services for educational purposes.
17. Splinting (if tooth does not otherwise need to be restored).
18. Services covered under Workers Compensation, or by Federal or State agencies.
19. Surgical implants or transplants of any type (including prosthetic devices, such as crowns, attached to them) and all related services, unless the 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.
20. Services performed by other than by a licensed dentist, except for legally delegated services to a licensed hygienist or licensed expanded functions auxiliary.
21. Treatment for Temporomandibular Joint Disease (TMJ) or Myofacial Pain Dysfunction Syndromes (MPD).
22. X-rays for TMJ.
23. Orthognathic surgery.
24. Services or supplies rendered, or furnished in connection with, any duplicate appliance.
25. Services or supplies which are not necessary according to accepted standards of dental practice.
26. Expenses incurred for more than two oral examinations and/or prophylaxis treatments during a calendar year.
27. Expenses incurred for the replacement of amalgams and/or composites more often than once in any two (2) year period.
28. Expenses incurred for the replacement of fixed bridgework, crowns, gold restorations and jackets more often than once in any five (5) year period.
29. Expenses incurred for the replacement of partial or full dentures more often than once in any five (5) year period.
30. Expenses incurred for replacement of an existing denture which is or can be made satisfactory.
31. Expenses incurred for relining of dentures more often than once in any three (3) year period.
32. Expenses incurred for a temporary full denture.
33. Expenses incurred for the retreatment of root canals if it has not been at least three (3) years since the previous root canal treatment.
34. Services which are determined to be eligible expenses under any medical plan in which the Member is enrolled.
35. House calls.

36. 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.
37. Any services not specifically listed as a Covered Dental Service.
38. Treatment by a member of the immediate family or a resident in the covered employee's home; self-treatment.
39. Acid etches.
40. Expenses for the completion of periodontal charting.
41. Asepsis.
42. Claims that are not received by DCP within one calendar year from the date of service.
43. Charges for services received after a Member has reached the Annual or Lifetime Maximum Benefits payable under the Plan.
44. 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.

## **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. When DCP receives a proposed treatment plan for services that are expected to exceed \$400, we will designate a dentist to review those services for coverage under the Plan. 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 DCP 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.

DCP 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. If additional information is necessary to process your request for pretreatment review, DCP 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 DCP within the 45 day period, DCP 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.

DCP 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. DCP will approve or deny a request for an extension of time or increase in the number of treatments within 24 hours of our 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, DCP will process your request for pretreatment review as soon as possible taking into account the dental circumstances, but not later than 72 hours after DCP receives the request. If additional information is needed to process the request, DCP will

notify you or your dentist as soon as possible, but no later than 24 hours after DCP receives 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 provide 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.

### **CLAIM FORMS**

You do not have to worry about filing a claim form. Your Participating Dentist will file the claim directly with DCP and payment will be made by DCP directly to the provider of dental services. *Your responsibility* is to always show your Identification Card to your Participating Dentist when you receive care. You will be responsible for paying the appropriate Copayment or Deductible, only.

**Claims sent to DCP from Non-Participating Dentists will be denied unless Prior Plan Approval has been obtained.**

### **CLAIMS PROCESSING PROCEDURES**

When we receive claims from your dentist, DCP will process those claims and make a determination in accordance with your Schedule of Benefits. If the claim is paid, payment will be sent directly to your dentist, and you will receive an explanation of the payment.

If the claim is denied in whole or in part, DCP will notify you and your dentist within a reasonable period of time, but generally not later than 30 days after DCP receives the claim.

If additional information is required to process your claim, DCP 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 DCP within the 45 day period, DCP 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 DCP, 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.



## **COORDINATION OF BENEFITS (C.O.B.)**

“Coordination of Benefits” is the procedure used to pay dental care expenses when a person is covered by more than one dental plan. DCP follows rules established by Ohio law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than your actual bills.

When you or your family members are covered by another group plan in addition to DCP, we will follow Ohio coordination of benefit rules to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan.

DCP pays for dental care only when you follow our rules and procedures. If our rules conflict with those of another plan, it may be impossible to receive benefits from both plans, and you will be forced to choose which plan to use.

### **Plans that do not Coordinate**

DCP will pay benefits without regard to benefits paid by the following kinds of coverage.

- Medicaid
- Group hospital indemnity plans which pay less than \$100 per day
- School accident coverage
- Some supplemental sickness and accident policies

### **How DCP Pays As Primary Plan**

- When we are primary, we will pay the full benefit allowed by your Plan as if you had no other coverage.

### **How DCP Pays As Secondary Plan**

- When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary.
- We will pay only for dental care expenses that are covered by your Plan.
- We will pay only if you have followed all of our procedural requirements, including care obtained from or arranged by your Participating Dental Provider, etc.
- We will pay no more than the “allowable expenses” for the dental care you receive. If our Allowable Expense is lower than the primary plan’s, we will use the primary plan’s allowable expense. That may be less than the actual bill.

### **Which Plan is Primary?**

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

1. *Non-coordinating Plan*

If you have another group plan which does not coordinate benefits, it will always be primary.

2. *Employee*

The plan which covers you as an employee (neither laid off nor retired) is always primary.

3. *Children (Parents Divorced or Separated)*

If the court decree makes one parent responsible for dental care expenses, that parent's plan is primary.

If the court decree gives joint custody and does not mention dental care, we follow the birthday rule.

If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

4. *Children and the Birthday Rule*

When your children's dental care expenses are involved, we follow the "birthday rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your children.

However, if your 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.

5. *Other situations*

For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule of Coordination of Benefits.

**Coordination Disputes**

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Please see the Complaint Procedures section of this Handbook for further information. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call (614) 644-2673 or 1-800-686-1526.

## **COMPLAINT PROCEDURE**

Dental Care Plus (DCP) recognizes its responsibility to provide Members with adequate methods to make inquiries and express concerns about DCP and Participating Dentists. The following procedure has been established to assure that the Member will receive a response to any complaint and formal redress if appropriate.

Initial entry in the Complaint Grievance Procedure will be through the Member Services Department of DCP. This will be an informal process, and 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 pretreatment estimate provided by DCP under the pretreatment review procedure or a decision by DCP to deny a claim for benefits, you have the right to file an appeal if your complaint is not resolved through the informal Complaint Procedure. The procedure for filing an appeal is described in the Appeal Procedure section. If your complaint does not involve the denial of a claim or a pretreatment estimate, 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 PROCEDURE**

An appeal must be filed in writing within 180 days following your initial receipt of a pretreatment estimate or notice that a claim has been denied. Appeals filed later than 180 days following your initial receipt of a pretreatment estimate or notice that a claim has been denied, will be denied. If you are appealing a pretreatment estimate which involves treatment of an urgent condition (as defined in the Pretreatment Review section), you may request an appeal by phone. All other appeals must be submitted in writing.

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 Dental Care Plus in the process of reviewing the claim or pretreatment review request. If the claim or pretreatment estimate was denied, in whole or in part, based on the professional judgment of a dentist that the treatment is experimental, investigational or not dentally necessary or appropriate, Dental Care Plus 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.

Your appeal will be reviewed by the Utilization Review/Quality Assurance Committee of Dental Care Plus, and the Committee will make a final determination on your appeal. You and your dentist will be notified of the final

determination as soon as possible taking into account the dental circumstances. If you are appealing a denial of a claim, you will be notified not later than 30 days after Dental Care Plus received the appeal. If you are appealing a pretreatment estimate, you will be notified not later than 15 days after Dental Care Plus received the appeal. If you are appealing a pretreatment estimate which involved urgent treatment, you will be notified as soon as possible, but not later than 72 hours after Dental Care Plus received the appeal.

Dental Care Plus will notify you and your dentist of the final determination in writing, or orally followed by a written confirmation if the appeal was of a pretreatment estimate involving urgent treatment. If your appeal is denied, the notice will include the specific reason for the denial and the specific plan 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 the appropriate state to review your complaint or appeal. In Ohio, the address is 2100 Stella Court, Columbus, Ohio 43215-1067; telephone (614) 644-2673 or 1-800-686-1526. In Kentucky, the address is 229 West Main Street, Frankfort, Kentucky 40602; telephone (502) 564-3630. In Indiana, the address is 311 W. Washington Street, Indianapolis, Indiana 46204-2787; telephone (317)232-2385.

### **ERISA APPEALS**

If you are covered under a group plan 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). You are not required to ask the Department of Insurance to review your appeal prior to filing an action under Section 502(a) of ERISA.

## **TERMINATION OF INDIVIDUAL COVERAGE**

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

1. The date the Contract is terminated, or with respect to any specific coverage item of the Contract, 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 DCP, if the Member is required to make a contribution.
3. In Ohio and Indiana, the date on which the Member moves out of the designated service area. In Kentucky, the date the Member moves outside a fifty (50) mile radius of the service area.
4. The date specified by the Enrolling Unit that a Subscriber or Family Dependent is no longer eligible for coverage under the terms of the Plan.
5. 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.
6. The date on which the Member is retired or pensioned, unless a specific coverage classification is specified for retired or pensioned individuals in the Contract.
7. The date of entry into military duty, except temporary duty of thirty (30) days or less.
8. For a Dependent Child, the end of month when the child no longer qualifies as a dependent.

### *Right of Recovery*

In the event that DCP incurs and pays any claims for services rendered to any Subscriber or Family Dependent after the termination date of the Subscriber's coverage, DCP reserves the right to recover those payments from the Subscriber.

## COBRA CONTINUATION COVERAGE

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.

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. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). 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.

*Disability Extension of 18-month Period of Continuation Coverage*

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the employer in a timely fashion, you and your entire 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 would have to started at some time before the 60th 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 employer is notified of the Social Security Administration 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.

*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](http://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.



## **RELATIONSHIP BETWEEN PARTIES**

The relationship between DCP and Participating Dentists is a contractual relationship between independent contractors. Participating Dentists are not agents or employees of DCP, nor is DCP, or any employee of DCP, an agent or employee of any Participating Dentists.

The relationship between a Participating Dentist and any Member is that of a dentist and patient. The Participating Dentist is solely responsible for the dental services provided to any Member.

## **PRONOUNS**

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

## **FINANCIAL STATEMENT**

The most recent financial statement is available to Subscribers at the offices of DCP during regular business hours.

## **GENERAL PROVISIONS**

DCP is not a member of any insurance guaranty fund and in the event of DCP's insolvency, the Member is protected only to the extent of the hold harmless provisions contained in DCP's contracts with Participating Providers.

In the event of DCP's insolvency or discontinuance of operation, the Member may be financially responsible for services rendered by a dentist that does not participate with DCP, regardless of whether or not DCP previously authorized those services.

Finally, Members will continue to receive coverage of services under certain circumstances, in the event of DCP's insolvency or discontinuance of operation. Information concerning these circumstances and extended coverage terms can be obtained by calling DCP at (513) 554-1100 or 800-367-9466.

# COMMON DENTAL TERMS

Amalgam.....	A metal alloy used as a restorative filling material.
Anesthesia .....	(local) Administration of a specific medication to achieve the absence of pain in a particular area of the body.  (general) A medication used to render the patient unconscious.
Caries .....	A disease caused from bacteria that progressively deteriorates a tooth. Commonly called decay.
Crown.....	An artificial crown is a total restoration of the exposed portion of a tooth.
Denture.....	A device that is a substitute for missing teeth.
Emergency Palliative Care .....	To relieve pain, but not cure the disease.
Endodontics .....	Treatment of disease of the dental pulp.
Fluoride .....	A solution applied topically to the teeth to help prevent dental decay.
Hygienist.....	A licensed trained person who cleans teeth and provides information on prevention of oral disease.
Inlay.....	A restoration usually of cast metal prepared to fit a tooth and cemented in place.
Onlay.....	A restoration cast to cover the entire chewing surface of a tooth.
Orthodontics.....	Specialty primarily concerned with the detection, prevention, and correction of abnormalities in the positioning of teeth in their relationship to the jaws (straightening teeth).
Pedodontics.....	Dentistry for children.

- Prophylaxis ..... The removal of tartar and stains from the teeth.  
Cleaning of the teeth by either a dentist or dental  
hygienist.
- Restoration..... Broad term that applies to repairing or  
restoring the shape, form, or function of a  
tooth or group of teeth.
- Root Canal..... Removal of the pulp tissue of the tooth, and  
after therapy sterilization, filling the spaces  
with a sealing material.

**DENTAL CARE PLUS, INC.**  
100 Crowne Point Place  
Cincinnati, Ohio 45241  
**(513) 554-1100 or 1-800-367-9466**  
**Fax (513) 554-3187**  
**[www.dentalcareplus.com](http://www.dentalcareplus.com)**

Rev 9/06



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 Care Plus (DCP) Member Handbook or Summary Plan Description and becomes part of the Eligibility Information section. The Eligibility section is hereby amended as follows.

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

- 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.

A handwritten signature in cursive script that reads "Anthony A. Cook".

Dental Care Plus, Inc.  
President/CEO