Foreword

The Plan is described in:

Part I – The DMO Dental Coverage – Primary Care Dentist Services

Part IA – The DMO Dental Coverage – Specialty Dentist Services

• Under the DMO Dental Coverage, Primary Care and Specialty Dentists furnish the services. There is no deductible and no annual maximum when Primary Care or Specialty Dentists furnish the services. There are copayments for certain dental services.

• The rules of any Effective Date of Coverage provision may delay the start of your coverage.

We believe this Program provides worthwhile protection for you and your family.
Contract Holder: Princeton University

Group Number: A-397432
Aetna U.S. Healthcare Dental Plan, Inc., (referred to in this Certificate as "Dental Plan") operates a prepaid dental care program, which provides dental care services and benefits to Members who are covered under this Certificate.

Dental Plan agrees with the Subscriber, subject to all the conditions and provisions of this Certificate to provide the services and benefits and other rights and privileges which are set forth in this Certificate.

This Certificate and all attachments and endorsements incorporated herein by reference are delivered by Dental Plan in consideration of the Contract Holder's payment of premiums and shall take effect on the Contract Effective Date. No services are deliverable under this Certificate in the absence of current payment of such premiums.

Under the Certificate, the Subscriber engages Dental Plan to provide dental services and benefits in accordance with the covenants and conditions hereafter provided and in reliance upon the statements of each Subscriber in his/her Enrollment Application.

This Certificate is governed by the laws of the state in which filed. The Certificate specifications and the conditions and provisions on this and the following pages, including the cover sheet, any amendments, riders or endorsements included at delivery or added thereafter, are part of the Certificate.

SECTION I - DEFINITIONS

A. The following words and phrases when used in this Certificate shall have, unless the context clearly indicates otherwise, the meaning given to them below:

1. **Contract** - The Group Dental Contract issued to the Contract Holder by Dental Plan.

2. **Contract Holder** - An employer or organization who agrees to remit the premiums for coverage payable to Dental Plan. The Contract Holder shall act only as an agent of Dental Plan Members in the Contract Holder's group, and shall not be an agent of Dental Plan for any purpose.

3. **Contract Year** - One (1) year period commencing on the effective date of the Contract or any anniversary date thereof, during which the Contract is in effect.

4. **Copayment** - The amount required to be paid by or on behalf of a Member in connection with the services set forth in Section II of this Contract.

5. **Covered Dental Services** - Those dental services and supplies provided to a Member, while the person is covered. Those services and supplies are subject to the limitations and exclusions of the Dental Plan.

6. **Dependent** - Any person in a Subscriber's family who meets all the eligibility requirements of Section IV. B of this Contract, has enrolled in Dental Plan, and is subject to premium requirements set forth in Section X of this Contract.

7. **Effective Date** - The commencement date of coverage under this Contract as shown on the records of Dental Plan.

8. **Emergency Condition** - Any traumatic injury or condition which occurs unexpectedly; requires immediate diagnosis and treatment in order to stabilize the condition; and has symptoms such as severe pain and bleeding.
9. **Group** - Those employees in the eligible class(es) as shown on the Cover Sheet of the Contract who are enrolled in Dental Plan and whose premiums are remitted to Dental Plan by the Contract Holder.

10. **Identification Card** - Card issued to each Dental Plan Member which displays the name of Member and the telephone number of the Primary Dentist chosen by the Member.

11. **Jaw Joint Disorder** - A Temporomandibular Joint (TMJ) Dysfunction or any similar disorder of the jaw joint, or a Myofacial Pain Dysfunction (MPD), or any similar disorder in the relationship between the jaw joint and related muscles and nerves.

12. **Member** - A Subscriber or Dependent as defined in this Section.

13. **Non-Participating (Non-Par) Dentist** - A Dentist who has not entered into a written agreement with the Dental Plan to provide covered services to covered persons.

14. **Open Enrollment Period** - A period of not less than ten (10) consecutive working days, each calendar year, when eligible employees of Contract Holder may enroll in Dental Plan without a waiting period or exclusion or limitation based on health status or, if already enrolled in Dental Plan, may transfer to an alternative health plan offered by Contract Holder.

15. **Out-Of-Area Emergency Dental Care** - Dental Care that is given to a Member by a Non-Par Dental Provider for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the Member’s home address. Coverage for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this Dental Care Plan.

16. **Primary Care Dentist (PCD)** - A state licensed dentist whose area of practice and training is general dentistry, and who has contracted with DPO (Dental Plan Organization) to provide dental services to Members. A PCD chosen by a Member takes effect as a Member’s PCD on the Effective Date of that person’s coverage.

   If a Member does not choose a PCD, Dental Plan will have the right to make a selection for that Member. Dental Plan will notify the Member of the selection.

   Members may change their PCD by notifying Dental Plan by telephone or in writing. The change will be effective as follows:

   - If the Dental Plan receives a request on or before the 15th day of the month, the change will be effective on the first day of the next month.
   - If the Dental Plan receives a request after the 15th day of the month, the change will be effective on the first day of the month following the next month.

17. **Subscriber** - A person who meets all applicable eligibility requirements of Section IV.A of this Contract, has enrolled in Dental Plan, and is subject to premium requirements set forth in Section X of this Contract.

**SECTION II - DENTAL BENEFITS**

The Member shall be entitled to the following dental benefits when provided by the Member's Primary Care Dentist or by a Non-Par Dental Provider in the case of Out-of-Area Emergency Dental Care.

**Copayment**: Each Member must pay part of the cost of the services or supplies for which coverage is provided under the Dental Care Plan. This is a copayment.

A copayment is separate from the Dental Plan’s compensation to Primary Care Dentists. For certain dental services, the copayment may represent the full payment to the Primary Care Dentist.
Applies to Covered Services Provided by Primary Care Dentists (PCD’s)

Copayment:

**PCD Services**
- **Type A Services** The Copayment percentage is 0%
- **Type B Services** The Copayment percentage is 0%
- **Type C Services** The Copayment percentage is 40%

This Dental Care Schedule applies to covered services provided by PCDs. It includes only services in the list below.

The next sentence applies if:

1. A charge is made for an unlisted service given for the dental care of a specific condition; and
2. The list includes one or more services that, under standard practices, are separately suitable for the dental care of that condition.

In that case, the charge will be considered to have been made for a service in the list that Aetna determines would have produced a professionally acceptable result.

**Primary Care Dentist Services**

**Type A Expenses**

**VISITS AND X-RAYS**
- Office visit for oral examination (limited to 4 visits per year)
- Emergency palliative treatment
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride (limited to 1 treatment per year and to covered persons under age 16)
- Oral hygiene instruction
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to covered persons under age 16)
- Pulp vitality test

**X-RAYS AND PATHOLOGY**
- Bitewing X-rays (limited to 1 set per year)
- Entire series, including bitewings, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical X-rays
- Intra-oral, occlusal view, maxillary, or mandibular
- Extra-oral upper or lower jaw
- Biopsy and histopathologic examination of oral tissue

**SPACE MAINTAINER** *Includes all adjustments within six months after installation.*
- Fixed, band type
- Removable acrylic with round wire clasp

**Type B Expenses**

**ENDODONTICS**
- Pulp capping
- Pulpotomy
- Surgical exposure for rubber dam isolation
- Root canal therapy, including necessary X-rays
  - Anterior
  - Bicuspid
RESTORATIONS AND REPAIRS
• Amalgam restoration
  1 surface
  2 surfaces
  3 or more surfaces
• Resin restoration (other than for molars)
  1 surface
  2 surfaces
  3 or more surfaces or incisal angle
• Retention pins
• Sedative fillings
• Stainless steel crowns
• Prefabricated resin crowns (excluding temporary crowns)
• Recementing inlays, crowns, bridges, space maintainers
• Tissue conditioning for dentures

PERIODONTICS
• Emergency treatment (abscess, acute periodontitis, etc.)
• Subgingival curettage (limited to 4 separate quadrants, every 2 years)
• Scaling and root planing (limited to 4 separate quadrants, every 2 years)
• Periodontal maintenance procedures following surgical therapy (limited to 2 per year)

ORAL SURGERY Includes local anesthetics and routine post-operative care
• Extractions, uncomplicated
• Surgical removal of erupted tooth
• Surgical removal of impacted tooth (soft tissue)
• Excision of hyperplastic tissue
• Excision of pericoronal gingiva
• Incision and drainage of abscess
• Crown exposure to aid eruption
• Removal of foreign body from soft tissue
• Suture of soft tissue injury

Type C Expenses

RESTORATIONS
• Inlays
  1 surface
  2 surfaces
  3 or more surfaces
• Onlays
  2 surfaces
  3 surfaces
  4 or more surfaces
• Crowns (including build-ups when necessary)
  Resin
  Resin with noble metal
  Resin with base metal
  Porcelain
  Porcelain with noble metal
  Porcelain with base metal
  Base metal (full cast)
  Noble metal (full cast)
  Metallic (3/4 cast)
  Post and core
• Pontics
  Base metal (full cast)
  Noble metal (full cast)
  Porcelain with noble metal
  Porcelain with base metal
  Resin with noble metal
  Resin with base metal

• Dentures and Partials (includes relines, rebases, and adjustments within six months after installation).
  Full (upper and lower)
  Partial
  Stress breakers (per unit)
  Stayplates
  Crown and bridge repairs
  Adding teeth to an existing denture
  Full and partial denture repairs
  Relining/rebasing dentures (including adjustments within six months after installation)
  Occlusal guard (for bruxism only) limited to 1 every 3 years

OUT-OF-AREA EMERGENCY CARE
“Out-Of-Area Emergency Dental Care” consists of Dental care that is given to a Member by a Non-Par Dentist for the palliative (pain relieving; stabilizing) treatment of an Emergency Condition. The emergency care is rendered outside of the 50 mile radius of the Member’s home address. Coverage for Out-Of-Area Emergency Dental Care is subject to specific limitations described in this Dental Care Plan.

When care for an Emergency Condition is received; a benefit will be paid for the reasonable charges incurred by a Member for such care. The amount paid will not be more than $100; regardless of the number of treatments needed for each separate Emergency Condition.

Payment will be made only if all of the following rules are met:

• The care meets the definition of Out-Of-Area Emergency Dental Care. Care is given more than 50 miles from the Member’s home address.
• The care is for the temporary relief of the Emergency Condition until the Member can be seen by the PCD.
• The person provides an itemized bill to the Dental Plan. It must describe the care given.
• The dental service given is listed on the Dental Care Schedule that applies.

SECTION III - EXCLUSIONS AND LIMITATIONS

A. Coverage is not provided for the following charges:

• Those for services and supplies which are covered in whole or in part:
  under any other part of this Plan; or
  under any other plan of group benefits provided by or through your Employer.
• Those for services and supplies furnished to diagnose or treat a disease or injury that is not a non-occupational disease or injury.
• Those for services and supplies not furnished by a Primary Care Dentist; except if provided as Out-of-Area Emergency Dental Care.
• Those for plastic, reconstructive, or cosmetic surgery or other dental services or supplies which are primarily intended to:
  improve;
  alter; or
  enhance appearance;
whether or not for psychological or emotional reasons. Facings on molar crowns or pontics will always be considered cosmetic.

- Those for or in connection with services or supplies that are, as determined by the Dental Plan, to be experimental or investigational. A drug, a device, a procedure or treatment will be determined to be experimental or investigational if:
  
  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing that it is experimental, investigational or for research purposes; or

  the written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

- Those for services which the Dental Plan defines as not necessary for the diagnosis, care, or treatment of the condition involved. This applies even if they are prescribed, recommended, or approved by the attending PCD.

- Those for services not listed as Covered Dental Expenses.


- Those for dental services given after the person's coverage in the Dental Plan ends.

- Those for out-of-area charges that the Dental Plan determines are not reasonable.

- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for: services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any individual in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This does not include a plan established by a government for its own employees or their dependents or Medicaid).

- Those for replacement of lost or stolen appliances; or extra sets of dentures; or other appliances.

- Those for dental services given after the person's coverage in the Dental Plan ends. However, the following will be covered if ordered prior to the date coverage ends and installed or delivered no more than 30 days after coverage ends:

  onlays; inlays; crowns; removable bridges; cast or processed restorations; dentures; root canals; and fixed bridgework.

Ordered means that prior to the date coverage ends:

As to a denture:

  impressions have been taken from which the denture will be prepared.

As to a root canal:

  the pulp chamber was opened.

As to any other item listed above:

  the teeth which will serve as retainers or support; or

  which are being restored; have been fully prepared to receive the item; and impressions have been taken from which the item will be prepared.

- Those for any of the following services:

  An appliance; or modification of one; if an impression for it was made before the person became a Member;
A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a Member.

Root canal therapy; if the pulp chamber for it was opened before the person became a Member.

- Those for treatment by other than a Dentist; except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a Dentist.

- Those in connection with a service given to a person age 5 or more if that person becomes a Member other than: (i) during the first 31 days the person is eligible for this coverage; or (ii) as prescribed for any period of open enrollment agreed to by the Employer and the Dental Plan. This does not apply to charges incurred:
  
  (a) After the end of the twelve month period starting on the date the person became a Member; or

  (b) As a result of accidental injuries sustained while the person was a Member; or

  (c) For a Primary Care Service in the Dental Care Schedule that applies shown under the headings Visits and Exams; and X-rays and Pathology.

- Those for a crown; cast; or processed restoration unless:
  
  it is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or

  the tooth is an abutment to a covered partial denture or fixed bridge for orthodontic treatment; except when shown in the Dental Care Schedule.

- Those for services done where there is no evidence of pathology; dysfunction; or disease other than covered preventive services.

Any exclusion above will not apply to the extent that:

- coverage is specifically provided by name in your Booklet-Certificate; or

- coverage of the charges is required under any law that applies to the coverage.

Dental Care Plan coverage is subject to the following rules:

Replacement Rule
The replacement of; addition to; or modification of:

- existing dentures;
- crowns;
- casts or processed restorations;
- removable bridges; or
- fixed bridgework

is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. Dental Care Plan must have been in force for the covered person when the extraction took place.

The existing denture, crown, cast, or processed restoration, removable bridge, or bridgework cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures, removable bridges, and fixed bridgework is subject to the requirements that such dentures, removable bridges, and fixed bridgework are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture, removable bridge, or fixed bridge installed during the prior 5 years.
Alternate Treatment Rule
If more than one service can be used to treat a covered person’s dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

- the service must be listed on the Dental Care Schedule;
- the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
- the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a Primary Care Dentist and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

- the copayment for the approved less costly service; plus
- the difference in cost between the approved less costly service and the more costly covered service.

SECTION IV - MEMBERSHIP ELIGIBILITY REQUIREMENTS

A. Subscriber Eligibility

1. To be eligible to enroll as a Subscriber, a person must be:
   a. an employee of a Contract Holder eligible on his or her own behalf to participate in or currently enrolled in a health care plan offered by Contract Holder to the Group; and
   b. a resident in the Dental Plan service area.

B. Dependent Eligibility

1. To be eligible to enroll as a Dependent, a person must be:
   a) the spouse of a Subscriber under this Contract; or
   b) a dependent unmarried child (includes natural, foster, step, and legally adopted children) residing with Subscriber or with Subscriber’s former spouse in the Dental Plan service area who is:
      i. under twenty-three years of age, or
      ii. twenty-three years of age or older but incapable of self-support due to mental retardation or physical handicap, either of which commenced prior to age nineteen, or
      iii. under twenty-five years of age and attending a recognized college or university, trade or secondary school on a regular basis.

2. Newborn children will be treated as Dependents from birth subject to enrollment requirements described in Section VI.B.

3. You may also cover as your dependent a person who is your domestic partner, as defined below. A domestic partner is a person:
   - who is of the same or opposite gender;
   - who is engaged in a spouse-like relationship with you;
   - who is at least 18 years of age and mentally competent to consent to a contract;
   - who is not related to you by blood;
   - who is not married to or legally separated from anyone else;
   - who has been residing with you in the same household for at least 6 months and intends to so reside indefinitely;
   - who is engaged in a committed relationship of mutual caring and support with you (This means that you are jointly responsible for each other’s common welfare and living expenses.); and
   - who is not in the relationship solely for the purpose of obtaining insurance.
You must complete and sign a “Declaration of Domestic Partnership” which is acceptable to your Employer. In addition, you must submit proof of at least three of the items from the following List of Items that May Serve as Proof of a Domestic Partnership:

- a joint deed, a mortgage agreement, or a common leasehold interest in property;
- common ownership of a motor vehicle;
- a driver’s license listing a common address;
- status as the other’s primary beneficiary for life insurance, for retirement benefits, or under a will;
- power of attorney for property or health care.

C. Change of Group Eligibility Rules

The eligibility of the Group, the composition of the Group and the eligibility requirements used to determine membership in the Group which exist at the effective date of this Contract are material to the execution of this Contract by Dental Plan. No change in the eligibility or participation requirements of the Group shall be permitted to affect eligibility or enrollment under this Contract unless such change is agreed to by Dental Plan and the Contract Holder, and is not otherwise contrary to State law, rules or regulations. Breach of this provision is considered a material breach of this Contract and may be the basis for termination under Section XII.B.3.

SECTION V - ENROLLMENT AND ENROLLMENT ELIGIBILITY DATES

A. Enrollment Procedure

Any person who satisfies the membership eligibility requirements described in Section IV is eligible to enroll in Dental Plan in accordance with Subsection B, below by submitting a completed Dental Plan enrollment application form to Dental Plan.

B. Enrollment Eligibility Date

The Enrollment Eligibility Date is the date that a person who satisfies the membership eligibility requirements described in Section IV is eligible to enroll in Dental Plan.

1. The Enrollment Eligibility Date for any person who satisfies the membership eligibility requirements described in Section IV on the Effective Date of this Contract shall be the same date as the Effective Date of the Contract.

2. The Enrollment Eligibility Date for any person who first satisfies the membership eligibility requirements described in Section IV after the Effective Date of this Contract shall be the first Premium Due Date following the date that such person satisfied the membership eligibility requirements.

SECTION VI - EFFECTIVE DATE OF COVERAGE

A. Effective Date of Coverage Other Than of a Newborn Child

Subject to payment of applicable premiums as provided by Section X and in accordance with the applicable provisions and conditions of this Contract, the effective date of a Member's coverage hereunder is:

1. The Member's Enrollment Eligibility Date (Section V.B above) provided that his or her completed Dental Plan enrollment application form is received by Dental Plan within 30 days of the Member's Enrollment Eligibility Date; or

2. If a completed Dental Plan enrollment application form is not received by Dental Plan within 30 days of the Member's Enrollment Eligibility Date (Section V.B), the effective date of Member's coverage is the next Open Enrollment Period during which Member's completed Dental Plan enrollment application form is received by Dental Plan.
B. **Effective Date of Coverage of a Newborn Child.** Coverage of a newborn child of a Member is effective at the time of birth and shall automatically extend for a period of 31 days following birth. The Subscriber shall have the right, within the 31 day period following the birth of the newborn child, to continue coverage for the child beyond the 31 day period by enrolling the newborn child as a Dependent Member in Dental Plan, provided that the Member eligibility requirements as described in Section IV are satisfied, all premium payments required by Section X are paid for said child, and a completed Dental Plan enrollment application form, specifically naming the newborn child to be added, is received by Dental Plan within 31 days following the birth of the child.

**SECTION VII - TERMINATION OF COVERAGE**

A. Coverage of a Member or Members under this Contract will terminate under any of the following conditions, and termination will be effective on the date indicated:

1. In the event that a Subscriber ceases to meet the eligibility requirements of Section IV.A of this Contract, coverage of Subscriber and Subscriber's Dependents, if any, will terminate on the next premium due date following the date on which the subscriber ceased to meet the eligibility requirements.

2. In the event that a Subscriber's Dependent ceases to meet the eligibility requirements of Section IV.B of this Contract or, in the case of a domestic partner, the relationship ends as indicated on the completed and signed Declaration of Termination of Domestic Partnership, coverage of such Dependent will terminate on the next premium due date following the date on which the subscriber ceased to meet the eligibility requirements.

3. In the event that Group coverage under this Contract terminates pursuant to Section XII, coverage of any Member under this Contract will terminate as provided in Section XII.

4. In the event that Subscriber or Subscriber's Dependents, if any, fails to make any contribution or copayment required under this Contract, coverage of Subscriber and Subscriber's Dependents, if any, will terminate (30) days after written notice is given to the Subscriber and Contract Holder by Dental Plan of such failure and subject to the Grievance Procedure set forth in Section VIII.J. At the effective date of such termination, prepayments received by Dental Plan on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to Contract Holder, and Dental Plan shall have no further liability or responsibility with respect to such Member or Members under this Contract.

5. In the event that a Subscriber becomes covered under an alternative dental plan or under any other plan, which is offered by, through or in connection with the Group in lieu of coverage under this Contract, coverage of Subscriber and Subscriber's Dependents, if any, will terminate under this Contract.

6. In the event that a Member acts fraudulently or makes a material misrepresentation in applying for or obtaining coverage under this Contract, or misuses the Dental Plan Identification Card, including but not limited to allowing a person other than the Member named on the Identification Card to use Dental Plan services, Member's coverage under this Contract shall be terminated not less than 15 days from the date written notice is mailed to Subscriber. In the absence of fraud or material misrepresentation, all statements made by any Member or any person applying for coverage under the Contract will be deemed representations and not warranties. No statement made for the purpose of obtaining coverage will result in the termination of coverage or reduction of benefits unless the statement is contained in writing and signed by the Member, and a copy of same has been furnished to Member.
7. In the event that Dental Plan or Primary Care Dentists, after reasonable efforts, are unable to establish and maintain what it and Member agree to be a satisfactory relationship with each other, then the rights of such Member under this Contract may be terminated on not less than 30 days written notice to Member and Contract Holder, subject to the Grievance Procedure described in Section VIII.J. At the effective date of such termination, prepayments received on account of such terminated Member or Members for periods after the effective date of termination shall be refunded to the Contract Holder, and Dental Plan shall have no further liability or responsibility under this Contract with respect to such Member or Members.

8. In the event the coverage of a Subscriber terminates for any reason listed in this section, coverage of Subscriber's dependents, if any under this Contract, will also terminate.

Reinstatement After Your Coverage Terminates: If your coverage terminates because your contributions are not paid when due, you may not be covered again for a period of two years from the date your coverage terminates. If you are in an eligible class, you may re-enroll yourself and your eligible dependents at the end of such two-year period. Your dental coverage will be effective as described in the Effective date of Coverage section of the Booklet-Certificate. Your dental coverage will be subject to any rules that apply to a person who enrolls after the first 31 days the person is eligible for the coverage.

SECTION VIII - GENERAL PROVISIONS

A. Identification Card
The Identification Card issued by Dental Plan to Member pursuant to this Contract is for identification purposes only. Possession of a Dental Plan Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card may be grounds for termination of Member's coverage pursuant to Section VII.A.6 of this Contract. If the Member who misuses the card is the Subscriber, coverage may be terminated for the Subscriber as well as any dependents. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Dental Plan Identification Card by any other person, such card may be retained by Dental Plan, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Grievance Procedure set forth in Section VIII.J of this Contract.

B. Necessary Care
Members will receive benefits under the Contract only for necessary care. Dental Plan may determine, following Utilization Review, whether any benefit provided under the Contract was necessary care.

C. Reports and Records
Dental Plan is entitled to receive from any provider of services to Member, information reasonably necessary to administer this Contract subject to all applicable confidentiality requirements as defined in Section IX.H of this Contract. By accepting coverage under this Contract, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to Member hereunder to disclose all facts pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Dental Plan upon request and to permit copying of Member's records by Dental Plan.

D. Refusal of Treatment
Member may, for personal reasons, refuse to accept procedures, medicines, or courses of treatment recommended by a Primary Care Dentist. If such Primary Care Dentist (after a second Primary Care Dentist's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to follow the recommended treatment or procedure, Member will receive no further treatment for the condition involved. In such case neither the Dentist, nor Dental Plan, will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition. Dental Plan will provide written notice to Member of a decision not to render further treatment for a particular condition. The decision is subject to the Grievance Procedure set forth in Section IX.I of this Contract. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.
E. Legal Action
No action at law or in equity may be maintained against Dental Plan for any expense or bill unless brought within the statute of limitations for such cause of action.

F. Inability to Provide Service
In the event that due to circumstances not within the control of Dental Plan including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Dental Plan's Primary Care Dentists or entities with whom Dental Plan has arranged for services under this Contract, or similar causes, the rendition of dental benefits or other services provided under this Contract is delayed or rendered impractical, Dental Plan shall not have any liability or obligation on account of such delay or failure to provide services except to refund the amount of the unearned prepaid premiums held by Dental Plan on the date such event occurs. Dental Plan is required only to make a good-faith effort to provide or arrange for the provision of service, taking into account the impact of the event.

G. Confidentiality
Information contained in the dental records of Members and information received from Dentists incident to the dentist-patient relationship shall be kept confidential and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract, or in the compiling of aggregate statistical data, may not be disclosed without the consent of the Member.

H. Appeals Procedure
Dental Plan has established a procedure for resolving complaints by covered persons. If you have a complaint, please follow this procedure:

• An Appeal is defined as a written request for review of a decision that has been denied in whole, or in part, for: claim payment, certification, eligibility, or referral, etc. This will be done after consideration of any relevant information.
• An Appeal must be submitted to Dental Plan within 60 days of the date Dental Plan provides notice of denial. The Dental Plan address is on your ID card.
• An acknowledgement letter will be sent to you within 5 days of Dental Plan’s receipt of the Appeal. This letter may request additional information. If so, it must be submitted within 15 days of the date of the letter.
• You will be sent a response within 30 days of Dental Plan’s receipt of the Appeal. The response will be based on the information provided with or right after the Appeal.
• If the Appeal concerns an eligibility issue, and if additional information is not submitted to Dental Plan after receipt of Dental Plan’s response, the decision is considered Dental Plan’s final response 60 days after receipt of the Appeal. For all other Appeals, if additional information is submitted to Dental Plan after receipt of Dental Plan’s response, it must be submitted within 15 days of the date of Dental Plan’s response letter.
• Dental Plan’s final response will be sent within 30 days from the date of Dental Plan’s first response letter.
• If additional time is needed to resolve the Appeal, Dental Plan will send you a letter indicating that additional time is needed; explaining why such time is needed; and setting a new date for a response. The additional time will not be extended beyond another 30 days.
• In any urgent or emergency situation, the Expedited Appeal procedure may be initiated by a telephone call to Member Services. Dental Plan’s Member services telephone number is on your ID card. A verbal response to the Appeal will be given to the provider within 2 business days, provided that all necessary information is available. Written notice of the decision will be sent within 2 business days of Dental Plan’s verbal response. If you are dissatisfied with Dental Plan’s response, the Appeal procedure outlined above may be utilized.
• Dental Plan will keep records of your complaint for 3 years.

I. Clerical Records
1. Dental Plan shall keep records of all Members.
2. The Group shall forward the information required by Dental Plan in Section XI of this Contract in connection with the administration of this Contract.
3. All records of the Group which are incident to the coverage provided under this Contract shall be available for inspection by Dental Plan at any reasonable time.
4. Dental Plan shall not be liable for the fulfillment of any obligation dependent upon such information prior to its receipt in a form satisfactory to Dental Plan.
5. Incorrect information furnished to Dental Plan may be corrected, provided that Dental Plan has not acted to its prejudice in reliance thereon. Coverage under this Contract shall not be invalidated by failure of the Group due to clerical error, provided all premiums are properly adjusted. However in no case will any changes, additions, or deletions in Dental Plan's Member list be made effective more than two (2) Premium Due Dates prior to the date Dental Plan is notified, in a written form satisfactory to Dental Plan, of the requested change, addition, or deletion.

J. Limitation on Services
Services are available only from Primary Care Dentists and Dental Plan shall not have any liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any, dentist or other person, institution or organization unless prior arrangements are made by Dental Plan.

K. Coordination of Benefits With Other Group Health Plans
None of these coordination of benefits rules will serve as a barrier to the Member first receiving direct health services from DPO (Dental Plan Organization) which are covered under this Contract.

The rules establishing the order of benefit determination between this Contract and any other plan covering the Member are as follows:

1. The benefits of a plan which does not have a coordination of benefits with other health plans provision shall in all cases be determined before the benefits of this Contract.

2. For those plans which have applicable Coordination of Benefit clauses, the following rules will apply:
   a. The benefits of a plan which cover the Member as other than dependent will be determined before the benefits of a plan which cover the Member as a dependent;
   b. Except as stated in subparagraph (c) below, when a plan and another plan cover the same child as a dependent of different parents:
      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
      2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
      3) If the other plan does not have the rule described above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
      4) The word "birthday" refers only to the month and day in a calendar year, not the year in which the person was born.
   c. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      1) First, the plan of the parent with custody of the child;
      2) Then, the plan of the spouse of the parent with custody of the child;
      3) Finally, the plan of the parent not having custody of the child; and
      4) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first.
d. The benefits of a plan which covers a person as an employee who is neither laid-off nor retired (or as that employee’s dependent) are determined before those of a plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (d) shall be ignored;

e. If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee, Member, or Subscriber longer are determined before those of the plan which covered that person for a shorter time.

3. If a Member who has enrolled under this Contract is entitled to maternity benefits under another contract or policy of insurance (such as extended benefits for pregnancies which began while the Member was enrolled under a previously held policy), DPO (Dental Plan Organization) will pay, subject to Copayments under this Contract, the difference between entitlements under this Contract and entitlements under the other contract or policy of insurance.

4. Member agrees to permit DPO (Dental Plan Organization) to coordinate its obligations under this Contract with payment under any other contract or policy of insurance that covers Member.

5. For purposes of these provisions, DPO (Dental Plan Organization) may release to or obtain from any insurance company or other organization any necessary information, subject to applicable confidentiality requirements, as defined in Section IX.L of this Contract. Any Member claiming benefits under this Contract must furnish to DPO (Dental Plan Organization) all information deemed necessary by it to implement this provision.

**SECTION IX - CONTINUATION OF COVERAGE**

A.1. The continuation of coverage rules of this section, IX.A.1., do not apply to any Contract Holder who normally employed fewer than 20 employees on a typical business day during the preceding calendar year. This exception applies to the number of employees employed, not the number of employees covered by a health plan, and includes full-time and part-time employees.

If a Member's coverage terminates due to termination of Subscriber's employment (other than by reason of Subscriber's gross misconduct) or reduction of hours of Subscriber's employment, Member may elect to continue coverage for 18 months after eligibility for coverage under this Contract would otherwise cease.

If Member's coverage terminates due to a) divorce or legal separation, b) Subscriber's death, c) Subscriber's entitlement to Medicare benefits, or d) cessation of dependent child status under Section IV.B. of this Contract, Member may elect to continue coverage for 36 months after eligibility for coverage under this Contract would otherwise cease.

Continuation coverage ends at the earliest of the following events:

a. The last day of the 18-month period.
b. The last day of the 36-month period.
c. The first day on which timely payment of premium is not made subject to Section X.A.
d. The first day on which the Contract Holder ceases to maintain any group health plan.
e. The first day on which a Member is actually covered by any other group health plan. In the event the Member has a pre-existing condition, and the Member would be denied coverage under the new plan for a pre-existing condition, continuation coverage will not be terminated until the last day of the 18-month continuation period, or the date upon which the Member's pre-existing condition becomes covered under the new plan, whichever occurs first.
f. The date the Member is entitled to Medicare.
g. The date the Member no longer resides in the service area.
The 18-month coverage period may be extended if an event which would otherwise qualify the Member for the 36-month coverage period occurs during the 18-month period, but in no event may coverage be longer than 36 months from the event which qualified the Member for continuation coverage initially.

In the event a Member becomes disabled within the meaning of the Social Security Act, and notifies the employer before the end of the initial 18-month period, continuation coverage may be extended up to an additional 11 months for a total of 29 months. This provision is limited to members who are disabled at the time of their qualifying event and only when the qualifying event is the employees reduction in hours or termination. The member may be charged a higher rate for the extended period.

Contract Holder is responsible for providing the necessary notification to Members as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986. Coverage for the sixty (60) day period will be extended only where the Subscriber or Dependent pays the applicable premium charges due within forty-five (45) days of submitting the application to the Contract Holder and Contract Holder in turn remitting same to DPO (Dental Plan Organization).

Premiums payable to DPO (Dental Plan Organization) for the continuation of coverage under this Section shall be due in accordance with the procedures of Section X and shall be calculated in accordance with applicable federal law and regulations.