CarePlus Dental Plans

DENTAL ASSOCIATES PLATINUM DENTAL INSURANCE CONTRACT

IMPORTANT - DENTAL ASSOCIATES PLATINUM Coverage is available ONLY to those who do not have any other dental coverage.

Notice of 10 Day Right to Return Contract: You may return this Contract within 10 days after receipt to Care-Plus Dental Plans, Inc. at 11711 W Burleigh St, Wauwatosa, WI 53222. If you do so, the Contract is void and all payments made under it shall be refunded.

DENTAL ASSOCIATES PLATINUM DENTAL CONTRACT Offered By Care-Plus Dental Plans, Inc. Address: 11711 W Burleigh St, Wauwatosa, WI 53222. Phone: 414-771-1711, 800-318-7007.

RENEWAL AT OPTION OF CARE-PLUS. Care-Plus reserves the right to amend the Contract in any manner at a Renewal Date. If the Contract is amended, Care-Plus will give notice of any new terms or rates at least 60 days prior to the Renewal Date. If Care Plus does not provide such notice, the new terms or rates will not take effect until 60 days after the notice is mailed or delivered, in which case the policyholder may elect to cancel the policy at any time during the 60 day period.

To be eligible for benefits under the Contract, dental services must be received from a Dental Associates Dentist.

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QUALITY IMPROVEMENT PLAN SUMMARY

Our mission is to make sure you, the policyholder, are completely satisfied. Therefore, we have established a quality improvement program that provides for credentialing our providers as well as the identification, evaluation and improvement of processes related to: access to care, continuity and coordination of care and quality of care.

Through process management activities, staff members are involved with the implementation of our quality improvement plan. Consistent with proposed quality objectives, cross-functional teams are assembled to address quality issues.

Additionally, policyholders play a vital role in improving the quality of care we provide. We rely on the feedback you provide through policyholder satisfaction surveys to improve our service and care. Please address your comments to Care-Plus at the address shown above.

RIGHTS AND RESPONSIBILITIES OF POLICYHOLDERS

POLICYHOLDER RIGHTS

Right To Choose
You have the right to choose the clinic from which you will receive services from among Dental Associates clinics.

Right To Information
You have the right to information on your dental plan relating to:

- Covered and excluded dental benefits
- Available general and specialty care providers
- Preventive care
- Your condition and its related care
- The process to make known a complaint or request, and
- Policies and procedures relevant to your care.

Right To Privacy and Confidentiality
You have the right to privacy and confidentiality of all communications and records on your care in accordance with applicable laws.

Right To Be Treated with Respect and Dignity
You have the right to be treated with respect and dignity regardless of your race, age, sex or creed.

Right To Participate in Your Care
You have the right to be active in decisions about your treatment. You have the right to a candid discussion of appropriate or dentally necessary treatment options for your condition, regardless of cost or benefit coverage. You have the right to be informed about the risks and benefits of treatment and to refuse care.

Right To Present a Complaint or Grievance
You have the right to voice concerns about your care and to receive a prompt and fair review of your complaints. You have the right to courteous and attentive treatment.

POLICYHOLDER RESPONSIBILITIES

You Must Know Your Benefits and Requirements
You have a responsibility to:

- Understand your dental plan benefits,
- Follow the required procedures, and
- Ask questions about things you do not understand.

You Must Provide Accurate Information
You have a responsibility to provide accurate and complete information about your health and dental history and your eligibility and enrollment. You have a responsibility to fulfill any financial obligations you may incur prior to you receiving services unless Dental Associates agrees otherwise.

You Should Participate in Your Care
You have a responsibility to participate in your care by:

- Asking questions to understand your condition,
- Following the recommended or agreed upon, treatment plan for your condition, and
- Making healthy lifestyle choices to try to maintain your oral health and prevent illness.

You Must Keep Your Appointments
You have a responsibility to keep your appointments or to give early notice if you must reschedule or cancel an appointment or it will be considered a missed appointment. You may be charged a fee for missed appointments.

You Must Show Consideration and Respect
You have a responsibility to show consideration and respect to health care providers, their staff and other patients.

TERMS AND CONDITIONS

TERMS
When used in this Contract, these terms have the following meanings:
"Application" means the Application for Dental Insurance provided by Care-Plus.
"Benefit Year" means the twelve-month period of your coverage under the Contract. This twelve-month period begins on the Effective Date.
"Care-Plus" means Care-Plus Dental Plans, Inc.
"Contract" means this Dental Contract that you entered into with Care-Plus by signing the application.
“Dental Associates” means Dental Associates, Ltd. of Wisconsin. Dental Associates has offices at multiple locations.
"Dentist" means any licensed dentist who is employed by or contracted with Dental Associates.
"Effective Date" means the date your coverage begins under the Contract.
"Family" means the following members of your family if you have paid the proper fee to cover them:

1. Your spouse or qualifying domestic partner.
2. Any children of your child from birth until your child is age 18.
3. Your children, except that a child shall not be eligible to receive coverage as a member of Your "Family" on the day in which he or she attains the age of 26. (The term "children" includes stepchildren, legally adopted children and children placed for adoption. A child placed for adoption shall be covered even if a court does not make a final order granting adoption; however, coverage will terminate when the child's adoptive placement with the insured terminates.)
   In addition, if a child is unmarried and is 18 years of age or older and was a full-time student under the age of 27 at the time they were called to active duty in the reserves or national guard, they will remain eligible under the parent’s plan beyond the age of 27 until they are no longer a full-time student.
4. Your handicapped children of any age who are totally and permanently disabled. The term "totally and permanently disabled" means the inability of such child to engage in any substantial gainful activity because of a medically determinable physical or mental disability.

"Grievance" means any dissatisfaction with Care-Plus, the Dentist, the administration, or claims practices or services provided under the Contract that is expressed in writing by or on behalf of a recipient of services under this Contract.
"Renewal Date" means the last day of the Benefit Year under this Contract.
"Termination Date" means the date on which your coverage under the Contract ends.

COVERAGE

1. You will be covered under the Contract after these three steps are taken:
   a. You complete the form(s) required by Care-Plus, including the Application.
   b. You pay Care-Plus the proper fee, as shown on the Application.
   c. Care-Plus approves your application.
2. Your coverage starts on the date the above steps are completed. This is your Effective Date.
3. A Family member's coverage starts on the first day you are covered and the person is a member of your Family.
4. Services performed prior to your Effective Date are not covered under this Contract.

BENEFITS

1. To be eligible for benefits under the Contract, you and your Family must receive dental services from a Dental Associates Dentist.

2. Any charges you are responsible for are due and payable prior to you receiving services or within the time periods otherwise agreed to by Dental Associates.
3. The charge that you are responsible for will be based on Dental Associates' fee schedule in place at the time of the procedure, less the percentage of benefit up until the maximum plan allowance has been met. "Percentage of Benefit" is the applied percentage for category of service shown in Exhibit A. The percentage is applied to the Dentist's charge for a service. For example, if the Dentist's fees for Direct Filling Procedures as set forth in Exhibit A are $100, the Benefit Percentage will be $60 (60%) of the fee. You will be liable for the remaining $40 (40%).
4. The goal of the Contract is to provide a dental insurance benefit to reduce out-of-pocket expenses for those without a commercial or primary dental insurance provider.
5. You will notify Care-Plus within 30 days of the date you obtain coverage under any other plan.

CONTRACT TERMINATION

1. This Contract is issued for one Benefit Year. It is renewable at the option of Care-Plus.
2. This Contract will terminate if you fail to pay any required premiums owed to Care-Plus by the end of the grace period, as explained below.
3. A person is no longer eligible for this coverage if he or she obtains other dental coverage in addition to this plan. The coverage under this plan for a person with other dental coverage will terminate on the date the person becomes covered under the other plan. No refunds will be provided.
4. The date on which coverage ends is your Termination Date.
5. When this Contract terminates, the right of you and your Family to benefits hereunder shall terminate immediately.
6. In the event that any services are required by you or a member of your Family or are performed after the right to benefits has terminated, expenses incurred for such care shall be the sole responsibility of you and/or the Family member.

GRACE PERIOD

If you fail to make any payment when due and such failure continues for more than 31 days following the Renewal Date, this Contract and all rights of you and members of your Family to receive benefits under it shall terminate.

DISENROLLMENT

In this section "you" refers to the policyholder and members of his or her Family covered by this Contract. Care-Plus may dis-enroll you, resulting in termination of coverage, for any one of the reasons described below:

1. You fail to pay a required premium within 31 days after the Renewal Date.
2. You permit someone else to use the enrollment identification or knowingly provide fraudulent information in applying for coverage or receiving services.
3. You pose a threat to providers, staff, other patients or other policyholders because of physical or verbal abuse.
4. You are unable to establish or maintain a satisfactory provider-patient relationship with a Dentist. Disenrollment only will occur after we provide you the opportunity to select an alternate provider, have made reasonable efforts to assist you in establishing a satisfactory provider-patient relationship, and have provided you with notice of the right to file a Grievance.

If you are dis-enrolled, you may appeal our decision by filing a Grievance.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Care-Plus may, without consent or notice, release to or obtain from any other insurance company, other organization or person, any information, which it deems to be necessary for payment of claims. Any covered person under this Contract shall furnish to Care-Plus such information as may be necessary to implement this provision.

RIGHT OF RECOVERY

Whenever payments have been made by Care-Plus in excess of the maximum amount of payment required, Care-Plus shall have the right to recover such excess payments. They may be recovered from among one or more of the following: any person(s) to or for whom such payments were made and any other insurers, organizations or insurance plans.

NOTICES
Notices to Care-Plus shall be sufficient if delivered by mail to its regular office address, or emailed to member services. Notices to you shall be sufficient if mailed to your address in our records at the time of notice, or emailed to you with your consent.

EVIDENCE OF PARTICIPATION
Your identification card shall be presented, or the fact of participation made known, to the Dentist when you or your Family receives dental care.

RELEASE OF INFORMATION
You expressly consent to, authorize and direct anyone from whom dental treatment or advice is being sought or rendered, to furnish and make available to Care-Plus all such dental, medical or surgical reports, records, radiographs and other information, or copies thereof, as Care-Plus may request.

PAYMENT OF BENEFITS
No person other than you or your Family is entitled to benefits under this Contract. Rights under this Contract are not assignable or transferable in any manner. They shall be forfeited if you, a member of your Family, or any other person, assigns, transfers or aids any other person in obtaining benefits under it.

LIMITATION OF ACTIONS
If you or your Family Member has a claim for loss, you must give Care-Plus written proof of such loss, including a description of the occurrence, character and extent of such loss, within 90 days of the date you first become aware of the loss otherwise such claim will not be valid.

CHANGES IN MEMBERSHIP STATUS
You shall notify Care-Plus within thirty (30) days of any change of address, changes in eligibility with another dental plan, or in the status of you or your Family resulting from birth, adoption, marriage, divorce or death. With regard to the addition of a newborn child under your coverage, you must notify Care-Plus within one year after the birth of the child and make all past-due payments within one year. With regard to the addition of an adopted child, you must notify Care-Plus and pay the required premium within sixty (60) days of the adoption or placement for adoption.

PROVISIONS PROHIBITED BY LAW
Any provision of this Contract that is prohibited by law shall be and become without force or effect but shall not invalidate or impair the enforceability of any other provision of this Contract.

ENTIRE CONTRACT
This Contract and the Application constitute the entire agreement between you and Care-Plus. There are no other conditions, promises or representations in addition to, or at variance with, any of the terms of this Contract and the Application.

INCONTESTABILITY, MISREPRESENTATIONS
No statement made by you with respect to the insurability of you or a member of your Family, except fraudulent misstatements, shall be used to void this Contract or to deny a claim for benefits or services rendered after the coverage has been in effect for two (2) years.

GRIEVANCE
1. You will be notified of your right to file a Grievance and the procedure to follow each time a claim or benefit is denied. This includes a refusal to refer you for additional services, or when disenrollment proceedings are initiated. The notification will state the specific reason for the denial or initiation of disenrollment proceedings. The Grievance procedure is outlined below.
2. In the event that you have a complaint or problem regarding services under the Contract, you should submit your Grievance in written form to Care-Plus' grievance committee. The grievance committee will acknowledge the Grievance within five (5) business days of receipt.
3. You have the right to appear before the grievance committee to present written or oral information and to question the person who made the initial determination that resulted in the Grievance. The grievance committee shall notify you of the date and time of the committee meeting at least seven (7) calendar days before the meeting is scheduled.
4. The committee will resolve your Grievance within thirty (30) calendar days of the date it was originally received. If the grievance committee needs additional time to resolve the Grievance, written notice will be provided to you. The notice will include the reason(s) the Grievance has not been resolved and the date you

might expect to receive a decision. No Grievance will be resolved later than sixty (60) days after the date we originally received it.

5. Should your health condition be such that waiting the regular thirty (30) days for resolution of the Grievance could have adverse effects on your health, you may request an expedited Grievance. You should call 414-771-1711 or 800-318-7007 and state that you would like an expedited Grievance. Care-Plus will resolve the Grievance as quickly as your health condition requires. No expedited Grievance will be resolved later than seventy-two (72) hours after Care-Plus receives it.
6. If you are dissatisfied with the response given by the grievance committee, you may, within ten (10) days after receipt of the decision, appeal in writing to the President of Care-Plus. The President shall consider your Grievance and shall notify you of his decision in writing.
7. If you are still not satisfied with the decision you may, within ten (10) days of receiving the decision appeal to Care-Plus's Board of Directors. The appeal will be reviewed at the next regularly scheduled Board of Director's meeting and the Board of Directors will notify you in writing of their decision. The decision of the Board of Directors will be final.
8. You may resolve your problem by taking the steps outlined above. You may also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/ or by contacting:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Or you can call 800-236-8517 outside of Madison or 608-266-0103 in Madison, and request a complaint form.

LAW

The internal law of the State of Wisconsin shall govern this Contract.

EXCLUSIONS AND LIMITATIONS

1. This Contract does not cover any services performed at offices other than Dental Associates.
2. This Contract does not cover care if benefits for that care are available to you under other medical or dental expense coverage. Should that occur, Care-Plus pays the part of any charge which is more than the other coverage's benefit, up to the extent of the Percentage of Benefit shown in Exhibit A. All other conditions and limitations still apply. Other medical or dental expense coverage includes:
   a. individual or family plan health insurance;
   b. group health insurance;
   c. medical or hospital service insurance;
   d. Medicare or Medicaid;
   e. HMOs, PPOs, and other prepaid coverage; and
   f. union, employer, or employee welfare benefit plans.
3. This Contract will not reimburse you for missed appointment charges.
4. A member of your Family will no longer be covered by the Contract if that person no longer meets the definition of Family.

EXHIBIT A: SCHEDULE OF DENTAL SERVICES AND BENEFITS

The benefits listed in this schedule are available only when services are provided by a Dentist (as defined under "Terms").

	Percentage of Benefit
DIAGNOSTIC	
Dental radiographs	100%
Routine oral exams	100%
PREVENTIVE	
Adult prophylaxis	100%
ANCILLARY	
Local anesthetic	100%
Intravenous sedation	20%
Injections of antibiotic drugs	20%
Emergency palliative treatment	20%
RESTORATIVE	
Filling procedures	60%
CROWNS	30%
PROSTHODONTICS	
Fixed bridgework (nonprecious and semiprecious only)	30%
Removable partial dentures	30%
Complete dentures	30%
Denture repairs and adjustments	30%
ORAL SURGERY	20%
ENDODONTICS	20%
PERIODONTICS	20%
IMPLANTS	20%
ANNUAL MAXIMUM PER PERSON	$1,500
ORTHODONTICS	20% - Unlimited Maximum

DENTIST LOCATIONS
Dental Associates has offices at multiple locations. See the Dental Associates website (www.dentalassociates.com) for a complete listing.