Dental Certificate

Say Cheese Dental Network

Client Number – 6614 and 6615

Subclient Number – 1162, 5812 and 5813

Plan Name: $750 Comprehensive Plan

Benefit Year: January 1 through December 31

Deductible: None

Maximum Benefit: $750 total per Covered Person per Plan Year on all services.

Say Cheese Dental Network

Dental Certificate

Say Cheese Dental Network

What Is a Dental Certificate?

The *Dental Certificate* describes Covered Dental Care Services, subject to the terms, conditions, exclusions and limitations of the Policy.

Introduction to Your Dental Certificate

This *Dental Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

What Are Defined Terms?

Certain capitalized words have special meanings. We have defined these words in *Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to Say Cheese Dental Network. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Defined Terms*.

How Do You Contact Us?

Call us at 1-888-454-4127 (TTY 711), Monday-Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m. Throughout the document you will find statements that encourage you to contact us for more information.

Say Cheese Dental Network

Your Responsibilities

Enrollment and Required Contributions

Benefits are available to you if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the requirements of the Policy issued, including the eligibility requirements.
- You must qualify as a Subscriber as that term is defined in *Defined Terms*.

Be Aware the Policy Does Not Pay for All Dental Care Services

The Policy does not pay for all dental care services. Benefits are limited to Covered Dental Care Services. The *Schedule of Covered Dental Care Services* will tell you the portion you must pay for Covered Dental Care Services.

Decide What Services You Should Receive

Care decisions are between you and your Dental Provider. We do not make decisions about the kind of care you should or should not receive.

Choose Your Dental Provider

It is your responsibility to select the dental care professionals who will deliver your care. We arrange for Dental Providers and other dental care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services.

If you fail to verify whether your treating Dental Provider's participation in the Network, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.

Member Cost Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Dental Care Services. These payments are due at the time of service or when billed by the Dental Provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Covered Dental Care Services*. You must also pay any amount that exceeds the Allowed Amount.

Cost of Excluded Services

You must pay the cost of all excluded services and items. Review the *Exclusions and Limitations* section to become familiar with the Policy's exclusions.

File Claims with Complete and Accurate Information

When you receive Covered Dental Care Services from an Out-of-Network provider, you may be responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *How to File a Claim*.

Say Cheese Dental Network

Covered Dental Care Services

When Are Benefits Available for Covered Dental Care Services?

Benefits are available only when all of the following are true:

- The dental care service, including supplies or Pharmaceutical Products, is only a Covered Dental Care Service if it is Necessary. (See definitions of Necessary and Covered Dental Care Service in *Defined Terms*.)
- You receive Covered Dental Care Services while the Policy is in effect.
- You receive Covered Dental Care Services prior to the date that any of the individual termination conditions listed in *When Coverage Ends* occurs.
- The person who receives Covered Dental Care Services is a Covered Person and meets all eligibility requirements specified in the Policy.

The fact that a Physician or other Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, or its symptoms does not mean that the procedure or treatment is a Covered Dental Care Service under the Policy.

This section describes Covered Dental Care Services for which Benefits are available. Please refer to the attached *Schedule of Covered Dental Care Services* for details about:

- The amount you must pay for these Covered Dental Care Services (including any Deductibles, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Dental Care Services (frequency and dollar limits on services and/or materials and waiting periods).

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Say Cheese Dental Network

Pre-Treatment Estimate

If the charge for a Dental Care Service is expected to exceed $500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a Pre-Treatment Estimate. If you desire a Pre-Treatment Estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental X-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Care Service under the Policy and estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

Pre-Treatment Estimate of benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment. The pre-treatment estimate is valid for 90 calendar days from the date we provide it to the Dental Provider. If you will not receive the services within the 90 calendar days, you or the Dental Provider must request another pre-treatment estimate from us.

Say Cheese Dental Network

Exclusions and Limitations

We Do Not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, and materials described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician or Dental Provider.
- It is the only available treatment for your condition.

The services, treatments, and materials listed in this section are not Covered Dental Care Services, except as may be specifically provided for in *Covered Dental Care Services* or through a Rider to the Policy.

Where Are Benefit Limitations Shown?

When Benefits are limited within any of the Covered Dental Care Service categories described in *Covered Dental Care Services*, those limits are stated in the corresponding Covered Dental Care Service category in the *Schedule of Covered Dental Care Services*. Limits may also apply to some Covered Dental Care Services that fall under more than one Covered Dental Care Service category. When this occurs, those limits are also stated in the *Schedule of Covered Dental Care Services* table. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

Exclusions

Except as may be specifically provided in the *Schedule of Covered Dental Care Services* or through a Rider to the Policy, the following are not Covered Dental Care Services:

1. Dental Care Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. Any treatment, device or pharmacological regimen that is the only available

treatment for a particular condition will not result in Coverage if the procedure is considered to be an Experimental, Investigational or Unproven Service.

8. Any implant procedures performed which are not listed as covered implant procedures in the *Schedule of Covered Dental Care Services*.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to you by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
11. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
12. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
13. Replacement of complete dentures, fixed and removable partial dentures or crowns, and implants, implant crowns, implant prosthesis and implant supporting structures (such as connectors), if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is due to patient non-compliance, the patient is liable for the cost of replacement.
14. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
15. Charges for failure to keep a scheduled appointment without giving the dental office a 24-hour notice, or the notice period as required by the Dental Provider in question.
16. Expenses for Dental Procedures that were received prior to you becoming enrolled under the Policy.
17. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
18. Attachments to conventional removable prostheses or fixed bridgework. This includes semi- precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
19. Procedures related to the reconstruction of a patient's correct Vertical Dimension of Occlusion (VDO).

20. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
21. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
22. Services rendered by a provider with the same legal residence as you or who is a member of your family, including but not limited to: spouse, brother, sister, parent or child.
23. Dental Care Services otherwise covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Care Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
24. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
25. Orthodontic Services, unless otherwise listed as a covered Benefit in the *Schedule of Covered Dental Care Services*.
26. Foreign Services are not covered unless required as an Emergency.
27. Dental Care Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
28. Any Dental Care Services or Procedures not listed in the *Schedule of Covered Dental Care Services.*

29. Services rendered while covered under this Policy which were also covered by a prior carrier will be reviewed based on current Policy Coverage. Any Policy Exclusions and/or limitations will apply based on when the Covered Dental Care Service was originally rendered.
30. Major restorative services relating to teeth that are not periodontally sound or that have a questionable prognosis of less than five years.
31. Surgical extractions of wisdom teeth.

Say Cheese Dental Network

When Coverage Ends

General Information about When Coverage Ends

As permitted by law, we may end the Policy and/or all similar benefit plans at any time for the reasons explained in the Policy.

Your right to Benefits automatically ends on the date that coverage ends. When your coverage ends, we will still pay claims for Covered Dental Care Services that you received before the date your coverage ended. However, once your coverage ends, we will not pay claims for any dental care services received after that date.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

  Your coverage ends on the date the Policy ends.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Subscriber. Please refer to *Defined Terms* for definitions of the terms "Eligible Person" and "Subscriber".

- **We Receive Notice to End Coverage**

  Your coverage ends on the date we receive the required notice from you to end your coverage, or on the date requested in the notice, if later.

Fraud or Intentional Misrepresentation of a Material Fact

We will provide at least 30 days advance required notice to the Subscriber that coverage will end on the date we identify in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

Say Cheese Dental Network

How to File a Claim

How Are Covered Dental Care Services from Network Providers Paid?

We pay Network providers directly for your Covered Dental Care Services. If a Network provider bills you for any Covered Dental Care Service, please contact us. However, you are required to meet any applicable deductible and to pay any required Copayments and Coinsurance to a Network provider. You will also be responsible for any charges that are not covered by the Policy to your Dental Provider.

How Are Covered Dental Care Services from an Out-of-Network Provider Paid?

When you receive Covered Dental Care Services from an Out-of-Network provider, you may be responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that dental care service will be denied or reduced, as determined by us. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and date of birth.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider(s) including a complete dental chart showing extractions, fillings or other Dental Care Services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports, as applicable.
- Casts, molds or study models, as applicable.
- An itemized bill which includes the CDT codes or a description of each charge.
- The date the dental disease began.

The above information should be filed with us at:
MEMBER REIMBURSEMENT CLAIMS
PO BOX 644
MILWAUKEE WI 53201.
If you would like to use a claim form, you may access a form on the Internet at **saycheesedentalnetwork.com** or call us at 1-888-454-4127 (TTY 711), Monday-Friday from 7 a.m. to 10 p.m., and Saturday from 8 a.m. to 5:30 p.m. and a claim form will be provided to you.

Payment of Benefits

When the Out-of-Network Member Reimbursement Form is completed, the reimbursement will be sent directly to the member. We will not reimburse third parties that have purchased or been assigned benefits by Physicians or other Dental Providers.

Say Cheese Dental Network

Coordination of Benefits

When Does Coordination of Benefits Apply?

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

The order of benefit determination rules below governs the order in which each Plan will pay a claim for benefits.

- **Primary Plan**. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses.
- **Secondary Plan**. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Say Cheese Dental Network

Defined Terms

Allowed Amounts - Allowed Amounts for Covered Dental Care Services, incurred while the Policy is in effect, are determined as stated below:

A. For Network Benefits, when Covered Dental Care Services are received from Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with that Dental Provider.

B. For Out-of-Network Benefits, when Covered Dental Care Services are received from Out-of-Network Dental Providers, Allowed Amounts are our contracted fee(s) for Covered Dental Care Services with a Network Dental Provider in the same geographic area.

Annual Deductible - the total of the Allowed Amount you must pay for Covered Dental Care Services in a calendar year before we will begin paying for Network or Out-of-Network Benefits in that calendar year. It does not include any amount that exceeds Allowed Amounts. The Schedule of Covered Dental Care Services will tell you if your plan is subject to an Annual Deductible.

Benefits - your right to payment for Covered Dental Care Services that are available under the Policy.

CDT Codes - mean the Current Dental Terminology for the current Code on Dental Procedures and Nomenclature (the Code). The Code has been designated as the national standard for reporting dental care services by the Federal Government under the Health Insurance and Portability and Accountability Act of 1996 (HIPAA) and is currently recognized by third party payors nationwide.

Coinsurance - the charge, stated as a percentage of the Allowed Amount, that you are required to pay for certain Covered Dental Care Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Dental Care Services.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Dental Care Service(s) or Dental Procedures - dental care services, including supplies or materials, which we determine to be all of the following:

- Necessary.
- Treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.
- Described as a Covered Dental Care Service in this *Dental Certificate* under *Covered Dental Care Services* and in the *Schedule of Covered Dental Care Services*.
- Not excluded in this *Dental Certificate* under *Exclusions and Limitations*.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Care Services, perform dental surgery or administer anesthetics for dental surgery.

Eligible Person – a person who meets the eligibility requirements and lives within the United States.

Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Experimental or Investigational Service(s) - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.
- Not demonstrated through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
- Pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics.

Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that sickness or condition.

Foreign Services - services provided outside the U.S. and U.S. territories.

Initial Enrollment Period - the first period of time when Eligible Persons may enroll themselves under the Policy.

Maximum Benefit - the maximum amount paid for Covered Dental Care Services during a calendar year for you under the Policy. The Maximum Benefit is stated in The Schedule of Covered Dental Care Services.

Natural Tooth - sound natural teeth are defined as teeth that are free of any pathological, functional or structural disorders at the time of injury and not having had any restorative treatment including, but not limited to fillings, root canals, crowns, caps and orthodontia in place at the time of trauma.

Necessary - Dental Care Services and supplies which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate; and

A. needed to meet your basic dental needs; and

B. rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Care Service; and

C. consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us; and

D. consistent with the diagnosis of the condition; and

E. required for reasons other than the convenience of you or your Dental Provider; and

F. demonstrated through prevailing peer-reviewed dental literature to be either:

    1. safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; or

    2. safe with promising efficacy:

        a. for treating a life-threatening dental disease or condition; and

        b. in a clinically controlled research setting; and

        c. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Care Service as defined in this *Dental Certificate*. The definition of Necessary used in this *Dental Certificate* relates only to Coverage and differs from the way in which a Dental Provider engaged in the practice of dentistry may define Necessary.

Network - when used to describe a provider of dental care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network. This does not include those providers who have agreed to discount their charges for Covered Dental Care Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Dental Care Services, but not all Covered Dental Care Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Dental Care Services and products included in the participation agreement and an Out-of-Network provider for other Covered Dental Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Dental Care Services provided by Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Network Benefits and how Network Benefits apply.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Dental Care Services received by providers that do not participate in the Say Cheese Dental Network, i.e. Out-of-Network providers. The *Schedule of Covered Dental Care Services* will tell you if your plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Network Member Reimbursement Form – is the form used when a Member paid for services received from an Out-of-Network Provider, and is requesting reimbursement from Say Cheese Dental Network.

Out-of-Network Provider – any provider that does not participate in the Say Cheese Dental Network.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not

mean that Benefits for services from that provider are available to you under the Policy.

Plan Year - The period of time, usually beginning with the Policy's effective date of any year and terminating on the same date of the succeeding year, when accumulators for applicable deductibles and plan maximums are calculated. If the Policy effective date is February 29, such date will be considered to be February 28 in any year having no such date.

Policy - the entire agreement issued that includes all of the following:

- Policy
- Application
- Riders
- Amendments

These documents make up the entire agreement.

Policy Charge - the sum of the Premiums for all Covered Persons enrolled under the Policy.

Premium - the periodic fee required for each Subscriber in accordance with the terms of the Policy.

Pre-Service Request - are requests that require prior authorization or Benefit confirmation prior to receiving dental care.

Pre-Treatment Estimate – an estimation of the cost for planned services.

Procedure in Progress - all treatment for Covered Dental Care Services that results from a recommendation and an exam by a Dental Provider. A treatment procedure will be considered to start on the date it is initiated and will end when the treatment is completed.

Rider - any attached written description of additional Covered Dental Care Services not described in this *Dental Certificate*. Covered Dental Care Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Schedule of Covered Dental Care Services – the Schedule of Covered Dental Care Services describes the Covered Dental Services and any applicable limitations to those services, such as applicable waiting periods, maximum benefits, and member cost share. If a specific service is not listed in the Schedule of Covered Dental Care Services**, it is not covered under your plan.**

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person on whose behalf the Policy is issued.

Usual and Customary - Usual and Customary fees are calculated by us based on available data resources of competitive fees in that geographic area.

Usual and Customary fees must not exceed the fees that the Dental Provider would charge any similarly situated payor for the same services. In the event that a Dental Provider routinely waives Copayments and/or the applicable deductible for benefits, Dental Care Services for which the Copayments and/or the applicable deductible are waived are not considered to be Usual and Customary.

Usual and Customary fees are determined solely in accordance with our reimbursement policy guidelines. Our reimbursement policy guidelines are developed by us, in our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As shown in the most recent edition of the *Current Dental Terminology*, a publication of the *American Dental Association*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination accepted by us.

Say Cheese Dental Network

Schedule of Covered Dental Care Services

How Do You Access Benefits?

This Schedule of Covered Dental Care Services: (1) describe the Covered Dental Care Services and any applicable limitations to those services; (2) outline the Copayment and/or Coinsurance that you are required to pay and the applicable Waiting Periods for each Covered Dental Care Service; and (3) describe the applicable Deductible and any Maximum Benefits that may apply.

If a specific service is not listed in the Schedule of Covered Dental Care Services, **it is not covered under your plan.**

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Dental Providers

We have arranged with certain Dental Providers to participate in a Network. These Network Dental Providers have agreed to discount their charges for Covered Dental Care Services and supplies.

If Network Dental Providers are used, the amount of Covered expenses for which you are responsible will generally be less than the amount owed if Out-of-Network Dental Providers had been used. The Copayment and/or Coinsurance level remain the same whether or not Network Dental Providers are used. However, because the total charges for Covered expenses may be less when Network Dental Providers are used, the portion that you owe will generally be less.

Directory of Network Dental Providers

A Directory of Network Dental Providers will be made available. You may access the Directory of Network Dental Providers online at **saycheesedentalnetwork.com**. You can also call customer service to determine which Dental Providers participate in the Network at 1-888-454-4127 (TTY 711), Monday-Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

Network and Out-of-Network Benefits

This Schedule of Covered Dental Care Services describes both benefit levels available under the Policy.

Network Benefits

Dental Care Services must be provided by a Network Dental Provider in order to be considered Network Benefits.

The only exception is if you need emergency care, and you are out of your service area or are unable to contact your Network general Dental Provider. In this situation, emergency care will be covered as a Network Benefit, and you will not be responsible for greater out-of-pocket expenses than if you had attended a Network Dental Provider. You must submit appropriate reports and X-rays for review.

When Dental Care Services are received from an Out-of-Network Dental Provider as a result of an Emergency, the Coinsurance will be the Network Coinsurance.

Enrolling for Coverage under the Policy does not guarantee Dental Care Services by a particular Network Dental Provider on the list of Dental Providers. **The list of Network Dental Providers is subject to change.** When a Dental Provider on the list no longer has a contract with us, you must choose among remaining Network Dental Providers.

You are responsible for verifying the Network participation status of your Dental Provider, prior to receiving such Dental Care Services. **If you fail to verify whether your treating Dental Provider's participation in the Network, and the failure results in non-compliance with our required procedures, Coverage of Network Benefits may be denied.**

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, and payment of the Coinsurance specified for any service shown in this *Schedule of Covered Dental Care Services* and generally require you to pay less to the Dental Provider than Out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Coverage for Dental Care Services is subject to payment of the Premium required for Coverage under the Policy, satisfaction of any applicable deductible, appropriate Waiting Period, and payment of the Coinsurance specified for any service shown in this *Schedule of Covered Dental Care Services* and generally require you to pay less to the Dental Provider than Out-of-Network Benefits. Network Benefits are determined based on the contracted fee for each Covered Dental Care Service. In no event will you be required to pay a Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee.

Network Benefits

When Network Coinsurance is charged as a percentage of Allowed Amounts, the amount you pay for Dental Care Services from Network Dental Provider is determined as a percentage of the negotiated contract fee between us and the Dental Provider rather than a percentage of the Dental Provider's billed charge. Our negotiated rate with the Dental Provider is ordinarily lower than the Dental Provider's billed charge.

A Network Dental Provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary, the Network Dental Provider may charge you. However, these charges will not be considered Covered Dental Care Services and will not be payable by us.

Out-of-Network Benefits

Out-of-Network Benefits apply when you obtain Dental Care Services from Out-of-Network Dental Providers.

Before you are eligible for Coverage of Dental Care Services obtained from Out-of-Network Dental Providers, you must meet the requirements for payment of the applicable deductible and appropriate Waiting Period stated below. Generally, you are required to pay more than Network Benefits. Out-of-Network Dental Providers may request that you pay all charges when services are rendered. You must file a claim with us for reimbursement of Allowed Amounts.

We will reimburse an Out-of-Network Dental Provider for a Covered Dental Care Service up to an amount equal to the contracted fee for the same Covered Dental Care Service received from a similarly situated Network Dental Provider. The actual charge made by an Out-of-Network Dental Provider for a Covered Dental Care Service may exceed the contracted fee. As a result, you may be required to pay an Out-of-Network Dental Provider an amount for a Covered Dental Care Service in excess of the contracted fee. In addition, when you obtain Covered Dental Care Services from an Out-of-Network Dental Provider, you must file a claim with us to be reimbursed for Allowed Amounts.

Say Cheese Dental Network

Schedule of Covered Dental Care Services

BENEFIT DESCRIPTION AND LIMITATION	SAY CHEESE NETWORK BENEFITS: This column indicates the percentage **allowed** by Say Cheese Dental Network.	OUT-OF-NETWORK BENEFITS: This column indicates the percentage **allowed** by Say Cheese Dental Network. You must also pay the amount of the Out-of-Network Dental Provider's fee, if any, which is greater than the Allowed Amount.
CLASS I DIAGNOSTIC SERVICES EXCEPT CONE BEAMS		
Bacteriologic Cultures	100%	20%
Viral Cultures	100%	20%
Intraoral Bitewing Radiographs Images Limited to one series of images per calendar year.	100%	20%
Panorex Radiographs Image Limited to one time per consecutive 36 months.	100%	20%
Oral/Facial Photographic Images Limited to one time per consecutive 36 months.	100%	20%
Cone Beam CT Capture and Interpretation with Limited Field of View - Less than One Whole Jaw Limited to one time every consecutive 60 months.	100%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Mandible Limited to one time every consecutive 60 months.	100%	20%
Cone Beam CT Capture and Interpretation with Field of View of One Full Dental Arch-Maxilla, With and Without Cranium Limited to one time every consecutive 60 months.	100%	20%
Cone Beam CT Capture and Interpretation with Field of View of Both Jaws, With and Without Cranium Limited to one time every consecutive 60 months.	100%	20%
Diagnostic Casts Limited to one time per consecutive 24 months.	100%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Extraoral Radiographs Images Limited to two images per calendar year.	100%	20%
Intraoral - Complete Series of Radiograph Images Limited to one time per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	100%	20%
Intraoral Periapical Radiographs Image Eight images per calendar year	100%	20%
Pulp Vitality Tests Limited to one charge per visit, regardless of how many teeth are tested.	100%	20%
Intraoral Occlusal Radiographs Image Limited to two images per six months.	100%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Vertical Bitewings, 7-8 Radiograph Images Limited to one series of images per consecutive 36 months. Vertical bitewings cannot be billed in conjunction with a complete series.	100%	20%
Periodic Oral Evaluation Limited to two times per consecutive 12 months.	100%	20%
Comprehensive Oral Evaluation Limited to new patients or two times per consecutive 12 months. Not covered if done in conjunction with other exams.	100%	20%
Limited or Detailed Oral Evaluation Limited to two times per consecutive 12 months. Only one exam is covered per date of service.	100%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Comprehensive Periodontal Evaluation - new or established patient Limited to two times per consecutive 12 months.	100%	20%
Oral Evaluation and Counseling Primary Caregiver Limited to two times per consecutive 12 months. Not covered if done in conjunction with other exams.	100%	20%
CLASS I PREVENTIVE SERVICES		
Dental Prophylaxis Limited to two times per consecutive 12 months.	100%	20%
Fluoride Treatments - adult Limited to one time per consecutive 12 months.	100%	20%
Scaling in moderate or severe gingival inflammation	100%	20%
CLASS II MINOR RESTORATIVE SERVICES		

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Amalgam Restorations Multiple restorations on one surface will be treated as a single filling.	50%	20%
Composite Resin Restorations -Anterior Multiple restorations on one surface will be treated as a single filling.	50%	20%
Composite Resin Restorations -Posterior Multiple restorations on one surface will be treated as a single filling.	50%	20%
Gold Foil Restorations Multiple restorations on one surface will be treated as a single filling.	50%	20%
CLASS III ENDODONTICS		
Apexification Limited to one time per tooth per lifetime.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Apicoectomy Limited to one time per tooth per lifetime.	50%	20%
Retrograde Filling Limited to one time per tooth per lifetime.	50%	20%
Hemisection Limited to one time per tooth per lifetime.	50%	20%
Root Canal Therapy Limited to one time per tooth per lifetime. Dentist cannot charge retreatment codes on tooth treated for the first 12 months.	50%	20%
Retreatment of Previous Root Canal Therapy Dentist who performed the original root canal should not be reimbursed for the retreatment for the first 12 months.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Root Resection/Amputation Limited to one time per tooth per lifetime.	50%	20%
Therapeutic Pulpotomy Limited to one time per primary or secondary tooth per lifetime.	50%	20%
Pulpal Therapy (resorbable filling) - Anterior or Posterior, Primary Tooth (excluding final restoration) Limited to one per tooth per lifetime. Covered for anterior or posterior teeth only.	50%	20%
Pulp Caps - Direct/Indirect - excluding final restoration Not covered if utilized solely as a liner or base underneath a restoration.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Pulpal Debridement, Primary and Permanent Teeth Limited to one time per tooth per lifetime. Not covered on the same day as other endodontic services.	50%	20%
Pulpal Regeneration - (Completion of Regenerative Treatment in an Immature Permanent Tooth with a Necrotic Pulp) does not include Final Restoration Limit one per tooth per lifetime.	50%	20%
CLASS III PERIODONTICS		
Crown Lengthening Limited one per quadrant or site per consecutive 36 months.	50%	20%
Gingivectomy/Gingivoplasty Limited one per quadrant or site per consecutive 36 months.	50%	20%

Say Cheese Dental Network

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Gingival Flap Procedure Limited one per quadrant or site per consecutive 36 months.	50%	20%
Osseous Graft Limited one per quadrant or site per consecutive 36 months.	50%	20%
Osseous Surgery Limited one per quadrant or site per consecutive 36 months.	50%	20%
Guided Tissue Regeneration Limited one per quadrant or site per consecutive 36 months.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Soft Tissue Surgery Limited one per quadrant or site per consecutive 36 months.	50%	20%
Surgical Revision Procedure Limited to one per quadrant consecutive 36 months.	50%	20%
Periodontal Maintenance Limited to two times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement. Is covered in combination with dental prophylaxis but not on same date of service, benefit is not to exceed in combination with dental prophylaxis four per consecutive 12 months.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Full Mouth Debridement Limited to once per consecutive 36 months.	50%	20%
Provisional Splinting Cannot be used to restore vertical dimension or as part of full mouth rehabilitation, should not include use of laboratory-based crowns and/or fixed partial dentures (bridges). Exclusion of laboratory-based crowns or bridges for the purposes of provisional splinting.	50%	20%
Scaling and Root Planing Limited to one time per quadrant per consecutive 24 months.	50%	20%

Schedule of Covered Dental Care Services

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Localized Delivery of Antimicrobial Agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report Limited to three sites per quadrant or 12 sites total for refractory pockets or in conjunction with Periodontal Scaling and Root Planing	50%	20%
CLASS III ORAL SURGERY		
Alveoloplasty	50%	20%
Biopsy Limited to one biopsy per site per visit.	50%	20%
Frenectomy/Frenuloplasty	50%	20%
Surgical Incision Limited to one per site per visit.	50%	20%
Removal of a Benign Cyst/Lesions Limited to one per site per visit.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Removal of Torus Limited to one per site per visit.	50%	20%
Root Removal, Surgical Limited to one time per tooth per lifetime.	50%	20%
Simple Extractions Limited to one time per tooth per lifetime.	50%	20%
Surgical Extraction of Erupted Teeth or Roots Limited to one time per tooth per lifetime.	50%	20%
Surgical Extraction of Impacted Teeth Limited to one per tooth per lifetime.	50%	20%
Surgical Access, Surgical Exposure, or Immobilization of Unerupted Teeth Limited to one per tooth per lifetime.	50%	20%

Schedule of Covered Dental Care Services

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Primary Closure of a Sinus Perforation Limited to one per tooth per lifetime.	50%	20%
Placement of Device to Facilitate Eruption of Impacted Tooth Limited to one time per tooth per lifetime.	50%	20%
Transseptal Fiberotomy/Supra Crestal Fiberotomy, by report Limited to one time per tooth per lifetime.	50%	20%
Vestibuloplasty Limited to one time per site per consecutive 60 months.	50%	20%
Bone Replacement Graft for Ridge Preservation - per site Limited to one per site per lifetime. Not covered if done in conjunction with other bone graft replacement procedures.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Excision of Hyperplastic Tissue or Pericoronal Gingiva Limited to one per site per consecutive 36 months.	50%	20%
Appliance Removal (not by dentist who placed appliance) includes removal of arch bar Limited to once per appliance per lifetime.	50%	20%
Tooth Reimplantation and/or Transplantation Services Limited to one per site per lifetime.	50%	20%
CLASS III ADJUNCTIVE SERVICES		
Analgesia Covered, when Necessary, in conjunction with Covered Dental Care Services.	50%	20%
Desensitizing Medicament	50%	20%
General Anesthesia Covered, when Necessary, in conjunction with Covered Dental Care Services.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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Local Anesthesia Not covered in conjunction with operative or surgical procedure.	50%	20%
Intravenous Sedation and Analgesia Covered, when Necessary, in conjunction with Covered Dental Care Services.	50%	20%
Therapeutic Drug Injection, by report/Other Drugs and/or Medicaments, by report Limited to one per visit	50%	20%
Occlusal Adjustment	50%	20%
Occlusal Guards Limited to one guard every consecutive 36 months and only if prescribed to control habitual grinding.	50%	20%

Schedule of Covered Dental Care Services

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Occlusal Guard Reline and Repair Limited to relining and repair performed more than six months after the initial insertion. Limited to one time per consecutive 12 months.	50%	20%
Occlusion Analysis - Mounted Case Limited to one time per consecutive 60 months.	50%	20%
Emergency Palliative Treatment Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.	50%	20%
Consultation (diagnostic service provided by dentists or physician other than practitioner providing treatment.) Not covered if done with exams or professional visit.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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CLASS III **MAJOR RESTORATIVE SERVICES** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement.		
Coping Limited to one per tooth per consecutive 60 months. Not Covered if done at the same time as a crown on same tooth.	50%	20%
Crowns - Retainers/Abutments Limited to one time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Crowns - Restorations Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	20%
Temporary Crowns - Restorations Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes.	50%	20%
Inlays/Onlays - Retainers/Abutments Limited to one time per tooth per consecutive 60 months. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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Inlays/Onlays - Restorations Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Not covered if done in conjunction with any other inlay, onlay and crown codes except post and core buildup codes.	50%	20%
Pontics Limited to one time per tooth per consecutive 60 months.	50%	20%
Retainer-Cast Metal for Resin Bonded Fixed Prosthesis Limited to one time per consecutive 60 months.	50%	20%
Pin Retention Limited to two pins per tooth; not covered in addition to cast restoration. Limited to one time per consecutive 60 months.	50%	20%

Schedule of Covered Dental Care Services

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Post and Cores Covered only for teeth that have had root canal therapy.	50%	20%
Re-Cement Inlays/Onlays, Crowns, Bridges and Post and Core Limited to one per consecutive 12 months. Limited to those performed more than 12 months after the initial insertion.	50%	20%
Protective Restoration Covered as a separate benefit only if no other service, other than X-rays and exam, were performed on the same tooth during the visit.	50%	20%
Stainless Steel Crowns Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth. Prefabricated esthetic coated stainless steel crown - primary tooth, are limited to primary anterior teeth.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services

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CLASS III **FIXED PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement.		
Fixed Partial Dentures (bridges) Limited to one time per tooth per consecutive 60 months.	50%	20%
CLASS III **REMOVABLE PROSTHETICS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement.		
Full Dentures Limited to one per consecutive 60 months. No additional allowances for precision or semi-precision attachments.	50%	20%

Schedule of Covered Dental Care Services

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Partial Dentures Limited to one per consecutive 60 months. No additional allowances for precision or semi precision attachments.	50%	20%
Relining and Rebasing Dentures Limited to relining/rebasing performed more than six months after the initial insertion. Limited to one time per consecutive 12 months.	50%	20%
Tissue Conditioning - Maxillary or Mandibular Limited to one time per consecutive 12 months.	50%	20%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to one per consecutive six months.	50%	20%

Say Cheese Dental Network

Schedule of Covered Dental Care Services		
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CLASS III **COSMETIC** Replacement of bridges, crowns, inlays or onlays previously submitted for payment under the plan is limited to one time per consecutive 60 months from initial or supplemental placement.		
Labial Veneer (laminate) - Chairside Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	20%
Labial Veneer (resin laminate) -Laboratory Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	20%
Labial Veneer (porcelain laminate) -Laboratory Limited to one time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.	50%	20%

Say Cheese Dental Network

Covered Dental Care Services are subject to satisfaction of any applicable Deductibles, Maximum Benefits and payment of any Coinsurance as stated below.

Cost Share: Deductibles and Benefit Maximums

Deductible: None

Maximum Benefit: $750 total per Covered Person per Plan Year on all services.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after dental care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior authorization or benefit confirmation prior to receiving dental care.

How to Request an Appeal

If you disagree with a pre-service request for benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to request an appeal at:

APPEALS
PO BOX 361
MILWAUKEE WI 53201

Your request for an appeal should include:

- The patient's name and Policy number.
- The date(s) of Dental Service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be chosen to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a Dental care professional with experience in the field, who was not involved in the prior determination. We may consult with or ask dental experts to take part in the appeal process. You consent to this referral and the sharing of needed dental claim information. Upon request and free of charge, you have the right to

reasonable access to and copies of all documents, records and other information related to your claim for Benefits. If any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the appeal will take place and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied request for benefits.
- For appeals of post-service claims as identified above, the appeal will take place and you will be notified of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure.

You may have the right to external review through an *Independent Review Organization (IRO)* upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in our decision letter to you.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Dental Provider should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Dental Provider to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Say Cheese Dental Network

Questions, Complaints and Grievances

The following terms apply to this section:

A "complaint" is your expression of dissatisfaction with us or any Network provider.

An "expedited grievance" is a grievance where any of the following applies:

- The duration of the standard resolution process will result in serious jeopardy to your life or health or your ability to regain maximum control.
- In the opinion of a Physician with knowledge of your condition, you are subject to severe pain that cannot be adequately managed without the care or treatment that is the subject of the grievance.
- A Physician with knowledge of your condition determines that the grievance should be treated as an expedited grievance.

"Grievance" means any dissatisfaction with our administration, that is expressed in writing to us, by you or on your behalf that includes any of the following:

- Provision of services.
- Determination to reform or rescind a policy.
- Claims practices.

To resolve a question, complaint, or grievance, just follow these steps:

What if You Have a Question?

Contact Customer Service at 1-888-454-4127 (TTY 711), Monday-Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

What if You Have a Complaint?

Contact Customer Service at 1-888-454-4127 (TTY 711), Monday-Friday from 7 a.m. to 10 p.m. and Saturday from 8 a.m. to 5:30 p.m.

If you would rather send your complaint to us in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Grievance Process

Each time we deny a claim or Benefit or begin disenrollment proceedings, we will notify you of your right to file a grievance.

We will acknowledge a grievance, in writing, within five business days of its receipt and resolve the grievance within 30 calendar days of its receipt. If we are unable to resolve the grievance within that time, we will extend the time period by an additional 30 calendar days. If you receive notification that the grievance has not been resolved, additional time is needed and the expected date the grievance will be resolved.

You or an authorized representative have the right to appear in person before the grievance committee to present written or oral information. We will notify you, in writing, of the time and place of the meeting at least seven calendar days before the meeting.

Following a review of your grievance, you will receive a written notification of the committee's decision, along with the titles of the people on the grievance committee.

What to Do if Your Grievance Requires Immediate Action

In situations where the normal duration of the grievance process could have adverse effects on you, a grievance will not need to be submitted in writing. Instead, you or your Physician should contact us as soon as possible. We will resolve the grievance within 72 hours of its receipt, unless more information is needed. If more information is needed, we will notify you of our decision by the end of the next business day following the receipt of the required information.

The expedited grievance process for urgent situations does not apply to procedures that we do not consider urgent situations.

What to Do if You Disagree with Our Decision

You may resolve your problem by taking the steps outlined above in the grievance process. You may also contact the OFFICE OF THE COMMISSIONER OF INSURANCE, a state agency which 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

Complaints Department

P.O. Box 7873

Madison, WI 53707-7873

or you can call 800-236-8517 (outside of Madison) or 608-266-0103 in Madison or email them at **complaints@ociwi.state.us** and request a complaint form.

Please note that our decision is based only on whether or not Benefits are available under the Policy. We do not determine whether the pending Dental Care Service is necessary or appropriate. That decision is between you and your Dental Provider.