



Superior Dental Care

EVIDENCE OF COVERAGE

OHIO

NOTE: This is SDC's general Evidence of Coverage (EOC) and is provided here for informational purposes only. It may not contain a listing of your plan's specific benefits or your specific eligibility. For your Schedule of Benefits or your group specific EOC, please contact your human resources representative or SDC's Dentist and Member Services Team at 1-800-762-3159.

NOTICE: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. READ ALL OF THE RULES VERY CAREFULLY, INCLUDING THE COORDINATION OF BENEFITS SECTION, AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

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EVIDENCE OF COVERAGE

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EVIDENCE OF COVERAGE (EOC)

(Under a Master Group Contract)

Issued by

Superior Dental Care, Inc. (SDC)

Superior Dental Care, Inc. is also referred to as "SDC" in this Evidence of Coverage.

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INTRODUCTION

We have prepared this EOC to help you understand how to use your dental plan. Please read it carefully and keep it in a convenient location for future reference.

SDC hereby certifies that you and any *Enrolled Dependents* named on the SDC identification card(s) for whom the required prepaid dental premium has been paid, are entitled to coverage under the Master Group Contract (referred to in this EOC as the Contract) provided they meet the eligibility requirements stated in the Contract.

Coverage under SDC is subject to the exclusions, limitations, conditions and other terms of the Contract. As an EOC, this document summarizes the provisions, but does not constitute the Contract. You may examine the Contract at the office of the *Enrolling Unit* during regular business hours.

DESCRIPTION OF COMPANY

Superior Dental Care (SDC) was founded in 1984 by a group of dentists with the mission of helping employers offer their employees affordable access to quality dental care. Today, SDC remains dedicated to this original mission as they lead the way in group dental and other ancillary benefits throughout Ohio, Kentucky and Indiana. SDC, now a Medical Mutual company, offers employers and their employees one of the largest dental networks in the country, Free Second Opinions on covered dental services, and Superior Wellness Bundles that combine SDC's dental plans with other ancillary group benefits; all with SDC's famous industry-leading customer service and support.

SERVICE AREA

SDC is licensed to sell to groups domiciled in Ohio, Kentucky and Indiana, with our network of participating dentists and specialists offering coverage across the country.

DEFINITIONS

All personal pronouns used in the EOC shall include either gender.

Active Employee – Is an employee currently on active pay status.

Active Pay Status - Means conditions under which an employee is eligible to receive pay, and includes, but is not limited to, vacation leave, sick leave, bereavement leave, administrative leave, compensatory time, holidays, and personal leave.

Allowable Amount – The maximum allowable fee assigned by SDC to each eligible service. The *Allowable Amounts* are determined by SDC to be fair and adequate reimbursement for each procedure and are adjusted from time to time.

Allowable Expense – Is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person.

Balance Bill – Any amount of the dentist's current charge that exceeds SDC's then current allowable amount for an eligible service. *Participating Dentists* are prohibited from collecting this amount (or *Balance Bill*) from a *Covered Person*. If seeking care from a *Non-Participating Dentist or Specialist*, you may be required to pay this amount to the treating dentist.

Closed Panel Plan – Please refer to the definition of *Network Only*.

Contract Maximum – The amount of dental expenses allotted to each member per *Contract Period*. This amount is made up of any payment made by SDC in the Preventive, if applicable, Basic and Major categories of coverage. Under each new *Contract Period*, a fresh *Contract Maximum* is granted per member.

Contract Period – The defined time during which your benefits will apply. This is typically a 12 month period of time; however please check with your employer to be sure.

Coinsurance – The out-of-pocket expenses that are directly payable by an *Enrolled Member* to the dentist. The *Coinsurance* is based on a percentage of the *Allowable Amount* assigned to eligible services.

Copay - The amount of dental expense, which you are responsible to pay directly to the treating dentist at the time of each benefit-eligible oral evaluation during the contract period. This amount is applied to oral evaluations in the Preventive Category only and is to be paid per Covered Person per occurrence, at the time of the visit.

Covered Person – Either the *Enrollee* or an *Enrolled Dependent*, but applies only while the coverage of such person under the Contract is in effect. In this EOC, the terms “you” and “your” refer to any *Covered Person*.

Custodial parent – Is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Deductible – The amount of dental expense, which you are responsible to pay before SDC begins calculations of benefits. Deductibles follow the Contract Period, have individual maximums, and may have family limits.

Eligible Person – An *Active Employee* of the *Enrolling Unit* who meets the eligibility requirements specified in the Contract and EOC.

Enrolled Member – The *Enrollee* and *Enrolled Dependents* enrolled in SDC to receive dental benefits. *Enrolled Members* may also be referred to as Members.

Enrolled Dependent – Unless other arrangements have been made with SDC by the employer, an *Enrolled Dependent* is a person enrolled for coverage under the Contract who is (1) the Enrollee’s spouse, or (2) a dependent child of either the *Enrollee* or the Enrollee’s spouse, subject to the following conditions and limitations:

- (1) The *Enrolled Dependent* must be within SDC’s service area unless court ordered coverage for dependent children living outside the service area is mandated;
- (2) *Enrolled Dependent* includes any stepchild, legally adopted child (or in the process of adoption) or foster child. Appropriate documentation must be forwarded to SDC;
- (3) *Enrolled Dependent* includes a child who is incapable of self-support because of mental disability or physical handicap as long as the subscriber submits proof of total disability; and
- (4) The term *Enrolled Dependent* does not include spouse or child on active duty in any military service of any country.

Enrollee – Any active employee eligible by virtue of employment to receive dental services provided under the Contract.

Enrolling Unit – The employer or other entity with whom the Contract is made.

Full-time Student – A person who is enrolled in and attending, full-time, a recognized course of study or training to include a state accredited: high school, vocational school, college or university (minimum 12 credit hours), and technical schools (cosmetology school, automotive, etc.).

In Network Benefits – Services provided by a participating dentist or specialist.

Lifetime Maximum (if applicable – check your ID card for your coverage) – The amount of orthodontia benefit allotted to each applicable member per lifetime while enrolled under a specific group contract as a *Covered Person* with SDC. Any orthodontic payments made by SDC will apply toward your orthodontia *Lifetime Maximum*. This maximum is accumulated over time per member and does not refresh each year like the *Contract Maximum*. The orthodontia *Lifetime Maximum* is a separate maximum from the *Contract Maximum*. Please see your Schedule of Benefits to see if Lifetime Maximums apply.

Medically Necessary – A pre-determined course of treatment that is appropriate to the evaluation and treatment of a disease, condition or illness and consistent with the applicable standard of care. This does not include cosmetic services.

Network Only – Is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with the Plan, and that excludes coverage for services provided by out of network providers, except in cases of emergency or those coordinated by SDC. This is also known as a *Closed Panel Plan*.

Non-covered/Ineligible Services – Services for which there is no contractual benefit and for which the member is responsible for the provider’s full charge. This includes excluded services.

Non-Participating Dentist or Specialist – Is any dentist who has not entered into an agreement with SDC to provide dental services to *Covered Persons* through *SDC's Network*.

Open Access – *The Plan* offering coverage in and out of *SDC's Network*.

Out of Pocket Maximum – The amount of dental expense which you are responsible for, per member, per Contract Period. Each new Contract Period, a new Out of Pocket Maximum is applied per member. The Out of Pocket Maximum is applied only to the In Network Benefits.

Out of Network Benefits – Services provided by a non-participating dentist or specialist.

Open Enrollment – Unless otherwise specified in the Master Contract, the month prior to the renewal of the Enrolling Unit's contract period in which an *Enrollee* may make enrollment changes as needed without the requirement of a *Qualifying Event* or in which an *Eligible Person* may elect or cancel coverage.

Participating Dentist or Specialist – Is any dentist who has entered into an agreement with SDC to provide dental services to *Covered Persons* through *SDC's Network*.

Pediatric Oral Health Benefits – Affordable Care Act compliant pediatric essential health benefits as defined in the Schedule of Benefits, if applicable.

Plan – Is the plan that offers coverage through SDC's Network of Dentists. Employers purchase this plan in three distinct ways. The *Plan* is offered either as *Network Only*, *Open Access* or as *Point of Service*.

Point of Service – This type of plan provides different levels of coverage in and out of network.

Schedule of Benefits/List of Covered Services – Is an attached listing of covered benefits and plan features.

SDC-Kids Plans – Pediatric dental plans federally certified to contain all the required pediatric oral benefits required under the Affordable Care Act. These certified benefits can be pediatric only or embedded in a standard group plan. SDC-Kids Plans contain no lifetime or annual maximum limits on the required pediatric oral benefits.

SDC's Network – Is the group of dentists and dental specialists who have entered into an agreement with SDC to provide dental services to *Covered Persons*.

Qualifying Event – Is an event that permits an *Enrollee* to make changes to his enrollment during the contract period (within 31 days of the Event). A *Qualifying Event* is defined by SDC and includes but is not limited to the following: employment termination, retirement, birth, divorce, marriage, death, change in employee status, spouse's loss of coverage, adoption/custody (requires court documentation), etc.

COVERAGE

SDC offers three types of coverage through *SDC's Network in this plan*:

Network Only – *The Plan* option offering coverage only through *SDC's Network*. Please check with your Employer to identify if this is the way they purchased your dental Plan through SDC. For *Network Only* coverage, payment is always directed to the *Participating Dentist or Specialist*.

Open Access – *The Plan* option offering coverage in and out of *SDC's Network*. Please be sure to check with your employer to identify if this is the way they purchased your dental plan through SDC. For *Open Access* coverage, payment for non-participating dentists or dental specialists, unless otherwise contracted, is always directed to the *Enrollee* and it is the *Enrolled Member's* responsibility to assure payment to the treating dentist.

Point of Service - *The Plan* option offering coverage in and out of *SDC's Network* but at different levels of coverage. Please be sure to check with your employer to identify if this is the way they purchased your dental plan through SDC. For *Point of Service* coverage, payment for non-participating dentists or dental specialists, unless otherwise contracted, is always directed to the *Enrollee* and it is the *Enrolled Member's* responsibility to assure payment to the treating dentist.

PARTICIPATING DENTISTS

Enrolled Members in the *Open Access* or *Point of Service* options are encouraged to seek service from a *Participating Dentist or Specialist* within the service area to maximize their benefits. ***Enrolled Members in the Open Access or Point***

of Service options seeking treatment from a non-participating dentist may be responsible for any amount over their coinsurance and SDC's reimbursement – otherwise known as the **Balance Bill**. Payments for these out of network services will be directed to the **Enrollee unless otherwise contracted**.

Enrolled Members in the Network Only option MUST seek service from a Participating Dentist or Specialist within the service area in order to receive their benefits. In most cases *Enrolled Members* should be able to seek service from their preferred dentist, since all licensed dentists within the service area are eligible to apply for participation with *The Plan*. A complete listing of *The Plan's participating dentists* is accessible via the SDC website (www.superiordental.com). At SDC's website, a function titled **Find A Dentist** facilitates a review of *The Plan's* entire network of *Participating Dentists* by using the search options provided. The data display for each dentist includes: name, address, phone number, specialty, and an indicator for SmileRider participation. If internet access is not available, a printed directory listing may be obtained from the *Enrolling Unit* or by contacting SDC's Dentist and Member Services Team at (937) 438-0283 or (800) 762-3159.

RELATIONSHIP BETWEEN PARTIES

The relationship between SDC and *Participating Dentists* is a contractual relationship between independent contractors. SDC is not a provider of dental services. *Participating Dentists* are not agents or employees of SDC nor is SDC or any employee of SDC an agent or employee of *Participating Dentists*. The relationship between a *Participating Dentist* and any *Enrolled Member* is that of a dentist and a patient. SDC does not endorse or control clinical judgment recommendations made by *Participating Dentists* or by dentists otherwise selected by you. The *Participating Dentist* is solely responsible for the dental services provided to an *Enrolled Member*.

SDC is not a member of a guaranty fund. In the event of insolvency, *Enrolled Members* are protected only to the extent that the hold harmless provision applies to the services rendered, and also *Enrolled Members* may be financially responsible for services rendered by a dentist that is not under contract to SDC, whether or not SDC authorized the use of the dentist. If SDC becomes insolvent or otherwise discontinues operations, the *Participating Dentists* have agreed to provide dental services to *Enrolled Members* as needed to complete any medically necessary procedures commenced but unfinished at the time of SDC's insolvency or discontinuance of operations.

The most recent audited financial statement is available to *Enrollees* at SDC's office during regular business hours.

ENROLLMENT

When an *Eligible Person* enrolls in the plan initially, he is required to stay on the plan for a full contract period while employed at the company he initially enrolled with SDC. Unless otherwise specified in the Master Contract, SDC offers *Open Enrollment* once per contract period during the month prior to the renewal of that contract period. *Open Enrollment* allows *Enrollees* to make enrollment changes as needed. An *Enrollee* can only make changes to his enrollment during the contract period if he has experienced a *Qualifying Event*. Consideration for or renewal of the Master Group Contract and/or individual application is not subject to genetic testing or any results therein.

The *Enrolling Unit* shall notify SDC at least monthly, but in no event later than 31 days after the effective date/*Qualifying Event* of any new enrollments, terminations or changes for an *Enrolled Member*.

EFFECTIVE DATE OF COVERAGE

The coverage of an *Eligible Person* shall become effective on the date the Contract takes effect, or as otherwise specified in the *Enrolling Unit's* application. Unless otherwise provided by the Contract, an *Enrollee* not actively at work (except while on paid vacation) on the date the Contract takes effect, shall have his coverage become effective on the date of his return to active full-time work. In no event shall an *Enrolled Dependent* of an *Enrollee* be covered under this Contract until the *Enrollee's* coverage becomes effective.

IDENTIFICATION CARDS

Your identification card(s) lists the names of all *Enrolled Members*. We encourage you to present your ID card at the time of service. This will assist in assuring that claims for eligible services are sent directly to SDC.

CLAIM FORMS

You **do not** have to file a claim form when seeking care from a *Participating Dentist*. The *Participating Dentist* shall seek compensation for covered services solely from SDC, except for applicable *Coinurance*, *Deductibles*, and *Copayments*

and payment always goes to the participating provider of dental services. It is your responsibility to show your SDC identification card to your *Participating Dentist* before you receive care. This will expedite the claims process since claims must be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status.

A *Non-Participating Dentist* is **not** required to submit a claim form on your behalf and you may be responsible for submitting your own claim form when seeking their care. A *Non-Participating Dentist* may also seek total compensation for services

prior to the submission of a claim form. All claims must be submitted and resolved within one year from the date of service to be considered for payment, regardless of enrollment status. These claims payments are directed to the *Enrollee* unless otherwise contracted.

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

COINSURANCE, DEDUCTIBLE, COPAY AND MAXIMUM BENEFITS

Coinsurance is the out-of-pocket expenses that are directly payable by an *Enrolled Member* to the dentist. The *Coinsurance* is based on a percentage of the *Allowable Amount* assigned to the eligible service and may be requested at the time of the service. Please keep in mind if the dentist's actual charge is less than SDC's *Allowable Amount*, the *Coinsurance* will be based on that dentist's charge. The *Coinsurance* is calculated after the *Deductible* has been assessed, if applicable. Refer to the *List of Covered Services* for your *Coinsurance* percentages and maximums per contract period.

Deductible is the amount of dental expense, which you are responsible to pay before SDC begins benefit calculations. *Deductibles* follow the contract period, and may have individual and family maximums. Refer to your List of Covered Services to determine if your plan has a *Deductible*. You are responsible for any non-covered service, ineligible service and the appropriate *Coinsurance* and *Deductibles*.

Copay is the amount of dental expense, which you are responsible to pay directly to the treating dentist at the time of each benefit-eligible oral evaluation during the contract period. This amount is applied to oral evaluations in the Preventive Category only and is to be paid per Covered Person per occurrence, at the time of the visit. Refer to your *List of Covered Services* to determine if your plan has a *Copay*.

Maximums are the amount of expense that SDC pays on each *Covered Person's* behalf and as defined by the specific plan design selected by your Employer.

COORDINATION OF THIS CONTRACT'S BENEFITS WITH OTHER BENEFITS

The 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 govern the order in which each *Plan* will pay a claim for benefits. The *Plan* that pays first is called the *Primary plan*. The *Primary plan* must pay benefits in accordance with its policy terms without regard to the possibility that another *Plan* may cover some expenses. The *Plan* that pays after the *Primary plan* is the *Secondary plan*. The *Secondary plan* may reduce the benefits it pays so that payments from all *Plans* does not exceed 100% of the total *Allowable Expense*.

COB Definitions

A. A *Plan* is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) *Plan* includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) *Plan* does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections [3923.37](#) and [1751.56](#) ; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate *Plan*. If a *Plan* has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate *Plan*.

B. *This plan* means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from *this plan*. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether *This plan* is a *Primary plan* or *Secondary plan* when the person has health care coverage under more than one *Plan*.

When *This plan* is primary, it determines payment for its benefits first before those of any other *Plan* without considering any other *Plan's* benefits. When *This plan* is secondary, it determines its benefits after those of another *Plan* and may reduce the benefits it pays so that all *Plan* benefits do not exceed 100% of the total *Allowable Expense*.

D. *Allowable Expense* is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any *Plan* covering the person. When a *Plan* provides benefits in the form of services, the reasonable cash value of each service will be considered an *Allowable Expense* and a benefit paid. An expense that is not covered by any *Plan* covering the person is not an *Allowable Expense*. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an *Allowable Expense*.

The following are examples of expenses that are not *Allowable Expenses*:

- (1) If a person is covered by 2 or more *Plans* that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an *Allowable Expense*.
- (2) If a person is covered by 2 or more *Plans* that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an *Allowable Expense*.
- (3) If a person is covered by one *Plan* that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another *Plan* that provides its benefits or services on the basis of negotiated fees, the *Primary plan's* payment arrangement shall be the *Allowable Expense* for all *Plans*. However, if the provider has contracted with the *Secondary plan* to provide the benefit or service for a specific negotiated fee or payment amount that is different than the *Primary plan's* payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the *Allowable Expense* used by the *Secondary plan* to determine its benefits.
- (4) The amount of any benefit reduction by the *Primary plan* because a covered person has failed to comply with the *Plan* provisions is not an *Allowable Expense*. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
- (5) The amount of any benefit reduction by the *Primary plan* because a covered person has failed to comply with the *Plan* provisions is not an *Allowable expense*. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a *Plan* that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the *Plan*, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more *Plans*, the rules for determining the order of benefit payments are as follows:

A. The *Primary plan* pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other *Plan*

- B.
- (1) Except as provided in Paragraph (2), a *Plan* that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both *Plans* state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the *Plan* provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a *Closed Panel Plan* to provide out-of-network benefits.

C. A *Plan* may consider the benefits paid or provided by another *Plan* in calculating payment of its benefits only when it is secondary to that other *Plan*.

D. Each *Plan* determines its order of benefits using the first of the following rules that apply:

- (1) Non-Dependent or Dependent. The *Plan* that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the *Primary plan* and the *Plan* that covers the person as a dependent is the *Secondary plan*. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the *Plan* covering the person as a dependent, and primary to the *Plan* covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two *Plans* is reversed

so that the *Plan* covering the person as an employee, member, policyholder, subscriber or retiree is the *Secondary plan* and the other *Plan* is the *Primary plan*.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one *Plan* the order of benefits is determined as follows:

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

- The *Plan* of the parent whose birthday falls earlier in the calendar year is the *Primary plan*; or
- If both parents have the same birthday, the *Plan* that has covered the parent the longest is the *Primary plan*.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

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

- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the *Plan* of that parent has actual knowledge of those terms, that *Plan* is primary. This rule applies to plan years commencing after the *Plan* is given notice of the court decree;
- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
- (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The *Plan* covering the Custodial parent;
 - The *Plan* covering the spouse of the Custodial parent;
 - The *Plan* covering the non-custodial parent; and then
 - The *Plan* covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one *Plan* of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The *Plan* that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the *Primary plan*. The *Plan* covering that same person as a retired or laid-off employee is the *Secondary plan*. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another *Plan*, the *Plan* covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the *Primary plan* and the COBRA or state or other federal continuation coverage is the *Secondary plan*. If the other *Plan* does not have this rule, and as a result, the *Plans* do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The *Plan* that covered the person as an employee, member, policyholder, subscriber or retiree longer is the *Primary plan* and the *Plan* that covered the person the shorter period of time is the *Secondary plan*.

(6) If the preceding rules do not determine the order of benefits, the *Allowable Expenses* shall be shared equally between the *Plans* meeting the definition of *Plan*. In addition, *This plan* will not pay more than it would have paid had it been the *Primary plan*.

Effect on the Benefits of This Plan

A. When *This plan* is secondary, it may reduce its benefits so that the total benefits paid or provided by all *Plans* during a plan year are not more than the total *Allowable Expenses*. In determining the amount to be paid for any claim, the *Secondary plan* will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any *Allowable Expense* under its *Plan* that is unpaid by the *Primary plan*. The *Secondary plan* may then reduce its payment by the amount so that, when combined with the amount paid by the *Primary plan*, the total benefits paid or provided by all *Plans* for the claim do not exceed the total *Allowable Expense* for that claim. In addition, the *Secondary plan* shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more *Closed Panel Plans* and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one *Closed Panel Plan*, COB shall not apply between that *Plan* and other *Closed Panel Plans*.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under *This plan* and other *Plans*. SDC may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under *This plan* and other *Plans* covering the person claiming benefits. SDC need not tell, or get the consent of, any person to do this. Each person claiming benefits under *This plan* must give SDC any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another *Plan* may include an amount that should have been paid under *This plan*. If it does, SDC may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under *This plan*. SDC will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by SDC is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us. Please see SDC's appeal procedure within this Evidence of Coverage. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department's website at <http://insurance.ohio.gov>.

SUBROGATION

In those instances where this section applies, it will be administered as required under O.R.C. 2323.44. If less than the full value of the tort action is recovered for comparative negligence, diminishment due to a party's liability under sections 2307.22 to 2307.28 of the Revised Code, or by reason of the collectability of the full value of the claim for injury, death, or loss to person resulting from limited liability insurance or any other cause, the subrogee's or other person's or entity's claim shall be diminished in the same proportion as the injured party's interest is diminished.

If a dispute regarding the distribution of the recovery in the tort action arises, either party may file an action under Chapter 2721 of the Revised Code to resolve the issue of the distribution of the recovery.

EMERGENCY CARE

If you are in a *Network Only* plan and are unable to receive emergency care from your *Participating Dentist*, you may receive care from a *Non-Participating Dentist*. Emergency care is limited to the relief of pain, bleeding, or swelling, but not the cure of the disease. Your *Participating Dentist* should be consulted for follow-up care.

A *Non-Participating Dentist* is not required to submit a claim form on your behalf and you may be responsible for submitting your own claim form when seeking emergency care. A *Non-Participating Dentist* may also seek total compensation for emergency care prior to the submission of a claim form.

PRE-DETERMINATION OF BENEFITS

Pre-determination of benefits is designed to assist you and your dentist in understanding your dental coverage BEFORE the services are provided. This process is necessary for treatment plans totaling \$400.00 or more and for periodontal services. A pre-determination is initiated when your dentist submits the proposed treatment plan. SDC's Dental Consultants review claims, determining whether the case presented meets the contracted benefit criteria. Once reviewed and processed, you and your dentist will be provided a description of your financial responsibility for the proposed service before the work begins.

Remember, a pre-determination of benefits is not a treatment authorization but an estimate of benefits payable by SDC based on your eligibility and claims history at the time of processing. Be sure to discuss your pre-determination of benefits with your dentist. If services are begun prior to pre-determination of benefits, you could be responsible for the full cost of treatment.

ALTERNATE BENEFITS

Alternate benefits may be received when there is more than one acceptable course of treatment. In this situation, SDC will provide benefits based on the least expensive, professionally accepted treatment. If you and your dentist choose a more expensive treatment, the additional cost will be your responsibility. Pre-determining benefits on costly services will avoid unexpected financial responsibilities which can be associated with alternate benefits.

EXAMINATIONS AND SECOND OPINIONS

SDC reserves the right to require additional examinations at no cost to the *Enrolled Member*. These examinations and/or second opinions help SDC determine payable benefits, when there may be questions concerning proposed or completed treatments.

CANCELLATION PRIVILEGES

If you are responsible for any part of a fixed periodic prepayment in connection with an enrollment agreement, you may cancel your enrollment within seventy-two hours after having signed the initial agreement or offer to enroll. Cancellation occurs when written notice of the cancellation is given to SDC. A notice of cancellation mailed to SDC shall be considered to have been filed on its postmark date.

TERMINATION OF COVERAGE & COBRA

Benefits for the *Enrollee* under the Contract shall automatically terminate on the earliest of the following dates:

- (1) The date the Contract is terminated, or with respect to any specific covered item of the Contract, the date such coverage item terminates.
- (2) The date which the required *Enrollee's* contribution toward the dental premium has not been paid to SDC, if the *Enrollee* is required to make a contribution, unless another date has been specified in the Contract.
- (3) The date on which the *Enrolled Member* moves out of SDC's service area.
- (4) The date on which the *Enrollee* is retired or pensioned, unless coverage classification is specified for retired or pensioned individuals in the Contract.
- (5) The date of entry into military duty, except temporary duty of 30 days or less.
- (6) The date as noted in the Contract for which a *Covered Person* ceases to be eligible.
- (7) The last day the *Enrollee* is in *Active Pay Status*.

Continuation of coverage under COBRA shall apply only to the *Enrolling Units* that are subject to the provisions of COBRA. A *Covered Person* should contact the Enrolling Unit's plan administrator to determine if he or she is eligible to continue coverage under COBRA.

APPEAL PROCESS

If an *Enrolled Member* has a complaint concerning their dental services, benefits, or quality of care under the Contract, the complaint may be directed to SDC in writing, via telephone call, or in person. This must be completed within six (6) months following SDC's determination of the claim(s) in question.

An authorized member of SDC's Dental Services Team will contact the *Enrolled Member* and attempt to resolve the complaint through informal discussions, consultations, or conferences. The Team Member will notify the *Enrolled Member* of the resolution of the complaint no later than thirty (30) days following receipt of the complaint.

If the *Enrolled Member* is not satisfied with the resolution through the "informal" process, the *Enrolled Member* may send a written request to SDC asking for reconsideration. This written request will be given to a Committee appointed by SDC, consisting of two dentist members, two consumer members, and one added representative. The Committee will be empowered to resolve or recommend resolution of the complaint.

If a hearing is necessary or requested by the Member, it will be held within forty-five (45) days following the receipt of the written request. At this time, testimony will be received from the *Enrolled Member*, staff persons, administrators, dentists, and other persons as considered necessary for a fair appraisal of the complaint.

The Committee will tell the *Enrolled Member* in writing of their findings within thirty (30) days of the conclusion of the hearing. If the finding is not acceptable to the *Covered Person*, the *Enrolled Member* has the right to contact or file a complaint with their State Department of Insurance. For your convenience, address and telephone information is included in this EOC for the Ohio, Kentucky, and Indiana Departments of Insurance.

Departments of Insurance

Ohio Department of Insurance

50 W. Town St. #300
Columbus, Ohio 43215-1067
(800) 686-1526 (Member Complaints)
(614) 644-2673 (Consumer Service)

Kentucky Department of Insurance

215 W. Main St.
P.O. Box 517
Frankfurt, KY 40602-0517
(800) 462-2081 or
(502) 564-3630 (Consumer Protection
And Education Division)

Indiana Department of Insurance

311 W. Washington St. # 300
Indianapolis, IN 46204-2787
(317) 232-2395 (Cons. Serv.)

Still Have Questions?

Our goal is to give you access to the most appropriate dental care available. If you have any problems or questions about your dental coverage, please contact us at:

Superior Dental Care, Inc.
6683 Centerville Business Parkway
Centerville, OH 45459

Local (937) 438-0283
Toll Free (800) 762-3159
Claims/Member Services Fax (937) 291-8695
www.superiordental.com