Oneida Nation

Employee Certificate

CARE-PLUS Dental Plans, Inc.

CERTIFICATE OF INSURANCE

under

ONEIDA NATION
Group No. PPD185
Issued by

CARE-PLUS Dental Plans, Inc.

PLAN ADMINISTRATOR: **Oneida Nation**
2630 West Mason Street
Green Bay, WI 54304

EMPLOYER I.D. #: **39-6081138**

EFFECTIVE DATE: **January 1, 2017**

This certifies that CARE-PLUS Dental Plans, Inc. has issued and delivered to the Policyholder a Group Contract insuring certain Participants covered by the Contract. Certain provisions of the Group Contract are summarized in the Plan Benefit Schedule Addendum "A" and the Procedures Description Addendum "B", which are attached hereto and made a part of this certificate.

This individual certificate is furnished in accordance with and is subject to the terms of the Group Contract. An individual is covered under the policy only if the terms, provisions and conditions of the policy have been satisfied. The coverage described in the policy is available to a person and his or her dependents only if the person is eligible, has enrolled for coverage and the proper fees have been paid by the Policyholder.

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Rd., Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
(800) 318-7007

CARE-PLUS SMILE ADVANTAGE DENTAL PROGRAM

PLAN BENEFIT SUMMARY

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OFFICES

DENTAL ASSOCIATES, LTD. OF WISCONSIN has offices at multiple locations. See the Dental Associates website (www.dentalassociates.com) for a complete listing.

CARE-PLUS DENTAL PLANS, INC.
DENTAL CARE GROUP POLICY

INTRODUCTION

Welcome to the "CARE-PLUS Smile Advantage" program. CARE-PLUS Dental Plans, Inc. ("CARE-PLUS") is a non-profit insurance company. CARE-PLUS was formed in 1983 to provide comprehensive dental care programs. CARE-PLUS is a managed care group dental insurance plan developed jointly by CARE-PLUS and Dental Associates, Ltd. of Wisconsin to provide both general and specialty dental care.

Members of CARE-PLUS Smile Advantage receive their care from Dental Associates, Ltd. of Wisconsin, one of the largest group practices in Wisconsin. The Dental Associates staff believes in establishing a positive doctor-patient relationship. This relationship is the cornerstone for a long-term program that emphasizes preventive care and early detection of problems. CARE-PLUS Smile Advantage is designed to encourage You to visit the dentist regularly.

Please take a few minutes to read through this Certificate so You may get a thorough understanding of Your Benefits and CARE-PLUS' policies and procedures.

This Certificate briefly summarizes the insurance Contract between CARE-PLUS and Your Group. The Master Group Contract governs the Benefits and limitations of Your coverage. You may review the Contract during normal business hours if You desire. Please call Your Group or CARE-PLUS.

QUALITY IMPROVEMENT
Summary

CARE-PLUS has established a quality improvement committee that identifies, evaluates and seeks to improve processes related to access to care and quality of care.

Through a series of project and process management activities, all staff members are involved with the implementation of our quality improvement initiatives. Additionally, Members play a vital role in improving the quality of care. Please bring any problems or complaints to our attention immediately.

RIGHTS AND RESPONSIBILITIES OF PARTICIPANTS

Participant Rights

Right To Choose
You have the right to choose the clinic from which You will receive services from among Dental Associates, Ltd's network of clinics.

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

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

Right To Privacy and Confidentiality
You have the right to privacy and confidentiality of all communications and records on Your care.

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

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

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

Participant Responsibilities

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

- Understand Your dental plan Benefits,
- Follow the required procedures, and
- Ask questions about things You do not understand.

You Must Provide Accurate Information
You have a responsibility to provide accurate and complete information about Your health and dental history and Your eligibility and enrollment. You have a responsibility to fulfill any financial obligations You may incur on the day You receive services.

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

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

You Must Keep Your Appointments
You have a responsibility to keep Your appointments or to give early notice if You must reschedule or cancel an appointment or it will be considered a missed appointment. A surgical appointment is considered "missed" if You do not show up or if You cancel with less than forty-eight (48) hours notice. All other appointments require twenty-four (24) hours notice of cancellation.

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

DEFINITIONS

When used and capitalized in this Certificate or any amendments or riders attached hereto, the terms listed below are defined as follows:

1. **Benefits**. Under the Contract, Benefits include the Dental Service and Emergency Service as described in the Plan Benefit Schedule.

2. **CARE-PLUS Dental Plans, Inc**. CARE-PLUS Dental Plans, Inc. is a Wisconsin corporation located in Milwaukee, Wisconsin. It will be referred to as CARE-PLUS in this Certificate.

3. **Charge**. A Charge is the usual, customary, and reasonable fee or cost for a Dental Service. Fees are usual, customary and reasonable if they do not exceed the cost usually charged by the individual rendering the service or the general level of fees for similar services charged by others within the community where rendered, taking into consideration the complexity of treatment required for the particular case. No agreement as to the fee between You and a person, firm or corporation providing or rendering services shall increase the liability of CARE-PLUS to pay more than the usual, customary, and reasonable fee.

4. **Contract**. The Contract is the agreement by CARE-PLUS to provide Benefits to the Group and includes the application You submitted to the Group and any supplements, amendments, endorsements or riders attached to the Contract.

5. **Dental Service**. Dental Service means those professional services of a Group Dentist that are generally and customarily prescribed except as expressly limited or excluded by the Contract.

6. **Dentist**. A Dentist is someone who is licensed as a Doctor of Dental Surgery or its equivalent and who is a professional practitioner authorized by law to practice dentistry.

7. **Effective Date**. Your Effective Date is the date on which You become covered for Benefits.

8. **Emergency**. A serious dental condition caused by dental disease or accident that arises suddenly. If not treated immediately, an Emergency would result in jeopardy to Your dental health.

9. **Emergency Service**. The services described as Emergency Service in the Plan Benefit Schedule.

10. **Grievance**. Any dissatisfaction with CARE-PLUS, a Primary Provider, the administration, claims practice or services provided under the Contract, expressed in writing by You or on Your behalf.

11. **Group**. The Group is the Employer through which You have this coverage.

12. **Group Dentist**. A Group Dentist means a Dentist who is employed by, associated with or engaged by Dental Associates, Ltd. of Wisconsin.

13. **Laboratory Charges**. Laboratory Charges are any charges incurred by a Group Dentist or charged to the Group Dentist by a dental laboratory. Laboratory Charges are charged for the preparation and

fabrication of space maintainers, all indirect restorations, prosthetic appliances, or the repair of the above.

14. **Member**. A Member is an employee (whether single or married) of the Group who is reported as eligible for Benefits under the Contract and for whom the proper fees have been paid.

15. **Out of Area Services**. Services rendered at a location outside the Service Area.

16. **Participant**. A Participant means any Member or his or her Dependents.

17. **Primary Provider**. Under the Contract, a Primary Provider is any provider selected by CARE-PLUS. Dental Associates, Ltd. of Wisconsin is currently the Primary Provider of Benefits for the Contract. Dental Associates has offices at the locations specified on the Plan Benefit Schedule.

18. **Service Area**. The geographic area within a 50-mile radius of a Primary Provider location.

19. **You**. The Member and his or her enrolled Dependents, unless specifically stated that "You" refers only to a Member or Dependent.

ELIGIBILITY

AN ELIGIBLE MEMBER:
is an employee (whether single or married) of the Group who is reported by the Group as eligible for Benefits under the Contract.

ELIGIBILITY REQUIREMENTS

An eligible Employee is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 30 or more hours per week, but for purposes of the Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary, leased, emergency temporary, part-time (under 30 hours), substitute relief, seasonal and retired employees.
- Employees working more than one non full-time position are not eligible for coverage.
- An Independent Contractor who signs an agreement with the employer as an Independent
- Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

COVERAGE APPLICATION DUE

For newly hired employees, applications for Plan coverage are due by no later than 75 days from date of hire.

WAITING PERIOD

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 90 calendar days of regular employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

If You do not elect coverage at time of hire, if eligible and You apply for coverage at any other time during a calendar year, coverage for you and any eligible Dependents begins on January 1 of the following year.

An eligible Dependent includes:

1. Your legally married spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. Documentation to determine Dependent eligibility will be required by the Plan Administrator.
2. A Dependent Child that resides in the United States until the Child reaches his or her 26th birthday.

The term “Child” includes the following Dependents:

- A natural biological Child;
- A step Child;
- A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO), as defined by the Omnibus Budget Reconciliation Act of 1993;
- A Child under Your (or Your spouse's) permanent Legal Guardianship pursuant to an order by a court of competent jurisdiction, as of the date of the court order, up to the age of 18 (refer to EXTENDED COVERAGE FOR DEPENDENT CHILDREN section regarding eligibility past age 18)

A Dependent does not include the following:

- A foster Child;
- A Child of a Domestic Partner or under Your Domestic Partner’s Legal Guardianship;
- Domestic Partners;
- An individual from whom You have obtained a legal separation or divorce – coverage terminates as of the date of legal separation;

- Niece or Nephew;
- Dependent placed for adoption – once Child placed, coverage terminates;
- Spouse from whom You are separated for 180 days.
- A Dependent Child if the Child is covered as a Dependent of another Employee at this company.
- A child under the age of 26 for whom you have voluntarily terminated your parental rights, as of the date of termination, or a child under the age of 26 for whom you have had your parental rights terminated involuntarily, as of the date of the termination; or a child under the age of 26 for whom you have voluntarily relinquished your parental rights pursuant to state law, as of the date of the relinquishment.

Employees have the right to choose which eligible Dependents are covered under the Plan provided they meet the definition of an eligible Dependent and all Plan eligibility requirements.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You are required to notify Your Employee Benefits Department regarding status changes that do affect or may affect eligibility status. You and Your Dependent have a notice obligation to notify the Plan within 30 days should the Dependent's eligibility status change throughout the Plan year.

DEPENDENT ELIGIBILITY PROOF DOCUMENTS

The Plan requires proof documents for all dependents You request coverage for. Proof documents include, but are not limited to:

Marriage Certificate; Birth Certificate;
Proof of Legal Adoption;
Proof of Legal Guardianship (up to age 18 unless disabled); Qualified Medical Support Court Order;
Proof of Disablement;
Proof of Child Placed for Adoption;
Proof of Loss of Health Coverage from an Employer (other than the Tribe);
Proof of federal tax dependency status as issued by the IRS.

Newly Hired Employees Dependents: Proof documents must be received and approved by the Tribe by no later than 75 days from the date of hire. Dependents will not be added for coverage if proof documents are not received and approved.

Proof documents for all other dependents You request Plan coverage for must be received by the Tribe by no later than 30 days from the date of the application for coverage. Dependents will not be added for coverage if proof documents are not received and approved.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

Policy Extension for Handicapped Children: A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

• If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof must be submitted as required; and
- The Employee must still be covered under this Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

Policy Extension for Children Under Legal Guardianship: A Dependent Child over 18 who was under the Legal Guardianship of a Plan subscriber may be eligible for extended Dependent coverage up to 26 under this plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 18th birthday;
- The Dependent Child is a federal tax dependent for You or Your Spouse according to the IRS and proof of tax dependency is provided to Plan Administrator by You at least annually;

A Dependent Child provided extended coverage past 18 due to a Guardianship, who at any time does not meet the above requirements, will be removed from the Plan and may not re-enroll.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 30days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent does not meet the qualifications of Dependent eligibility, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for coverage. Please refer to the COBRA Section in this document.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin:

- If You apply within Your Waiting Period, Your coverage will become effective the first day following the date You complete Your Waiting Period.

- You must apply for enrollment within 75 calendar days from your hire date or be considered a late enrollee. Late enrollees may enroll for coverage for themselves and their eligible dependents at any time during the calendar year for a coverage effective date of January 1 of the following year.

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 75 days after Your hire date, or more than 30 days following the date You acquire the Dependent. You may apply for enrollment for a Dependent considered a Late Enrollee at any time during the calendar year for a coverage effective date of January 1 of the following year.
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the plan administrator determines that the order is a QMCSO.
- If Dependent coverage is requested due to a voluntary loss of benefits, coverage for the Dependent will become effective the first day following a 90-day waiting period.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

A DEPENDENT IS:

1. The Member's legal spouse.
2. The Member's unmarried children, including stepchildren, legally adopted children, and children placed for adoption with the Member, for whom the proper fees have been paid. A child placed for adoption shall be covered even if a court does not make a final order granting adoption; however, coverage will terminate if the child's adoptive placement with the Member terminates.

   A child ceases to be a Dependent on the day in which he or she attains the age of 26.

   A child continues to be an eligible Dependent beyond the limiting age above if he or she is unable to support himself or herself due to mental retardation or physical handicap. You must send CARE-PLUS a Doctor's certification of disability at least 31 days before the child reaches the limiting age and as often as CARE-PLUS requests for the following 2 years. After that, CARE-PLUS will request proof of disability annually.

3. The Member's children pursuant to a qualified medical child support order.

ENROLLMENT

INITIAL ENROLLMENT PERIOD: At the time the Group is initially enrolled, each Member shall complete a CARE-PLUS application form. The Effective Date for Members enrolled during the initial enrollment period is the date the Contract begins.

SUBSEQUENT ENROLLMENT PERIOD: This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other coverage or a change in family status as explained below. Special enrollment rights are triggered by a qualifying event. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF COVERAGE: Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other coverage.

If the following conditions are met:

- You and/or Your Dependents were covered under a group plan or insurance policy at the time coverage under this Plan is offered; and

- The coverage under the other group plan or insurance policy was:

- COBRA continuation coverage and that coverage was exhausted; or
- Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
- Terminated and no substitute coverage is offered; or
- Exhausted due to an individual meeting or exceeding the applicable maximum benefits on the plan; or
- No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended.

- You and/or Your Dependents were covered under a federal or state plan and You or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for coverage under this Plan due to loss of coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may

enroll for coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR EMPLOYMENT ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage (Note: Eligible individuals must submit their enrollment forms prior to the Effective Date of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

IDENTIFICATION CARDS: Initial and subsequent Members will receive a CARE-PLUS identification card.

CHANGES IN MEMBERSHIP STATUS. You should notify Your Group as soon as possible of any change of address or in Your membership status resulting from marriage, divorce, separation, death, birth or the adoption of a child.

APPOINTMENTS: Each Member, including Dependents, must select a primary dental center. For convenience or doctor preference, all family members are not required to select the same center. If You desire to be treated at one center and a member of Your family prefers another center, simply contact CARE-PLUS and we will make the arrangements.

You are eligible to receive treatment as of Your Effective Date. To schedule an appointment, please call the number assigned to the center of Your choice.

With CARE-PLUS Smile Advantage, You also have the right to change Your Group Dentist or dental center at any time, for whatever reason.

BROKEN APPOINTMENTS

If You break an appointment without at least forty-eight (48) hours notice for a surgical appointment or twenty-four (24) hours notice for all other appointments, the Dentist may charge a fee for the block of time reserved. This fee is not covered under the Contract.

BENEFITS

The Benefits available to You are the Dental Services and Emergency Service set forth in the attached Benefit Schedule and Procedure Description.

EXCLUSIONS AND LIMITATIONS

Benefits shall not include:

1. Dental Services not specifically described in the Contract as a Benefit.

2. Dental Services with respect to congenital malformations or that are primarily for cosmetic or esthetic purposes, except congenitally missing teeth.

3. Any duplicate prosthetic device or any other duplicate appliance, except as otherwise provided.

4. The replacement of a lost or stolen prosthetic device or appliance, except as otherwise provided.

5. The replacement of an orthodontic appliance, except as otherwise provided.

6. Treatment of temporomandibular joint (TMJ) dysfunction.

7. Gold foil, gold or precious metal restorations, except when used as necessary functional material.

8. Transplants.

9. Dental Service or Emergency Service:

   (a) That would be furnished, without charge, to You by any person or entity other than CARE-PLUS;

   (b) That You would be entitled to have furnished or paid for, fully or partially, under any law, regulation or agency of any government;

   (c) That You are entitled or would be entitled if You were enrolled, to have furnished or paid for under any voluntary medical or dental insurance plan established by any government if the Contract were not in effect;

   (d) To the extent that Medicare is Your primary payor, which it is, except where Medicare is secondary by law. Where Medicare is primary payor, no Benefits are available to the extent You

would have been entitled to Medicare benefits had You enrolled in Medicare or complied with Medicare requirements.

(e) For, or resulting from injuries, disease or conditions for which You receive, or are the subject of, any award or settlement under a Workers Compensation Act or any Employer Liability Law; or

(f) Rendered or furnished after the date You cease to be covered under the Contract, unless your cessation of coverage is not due to a termination of the Contract, in which case coverage may continue for You until the earlier of the date You are covered by an alternative dental policy or the date the Contract is no longer in force. Continued coverage is only available for:

(i) Procedures (other than prosthetic services) commenced prior to, and completed in one visit within thirty-one (31) days following termination of coverage; and

(ii) Prosthetic devices that are ordered and fitted prior to, and completed within sixty (60) days following, termination of coverage.

(g) Provided at a location other than the offices of the Primary Provider except for Emergency Service.

10. Hospital or physician services of any kind whether or not related to covered Dental Services.

11. Dental Service and Emergency Service resulting from diseases contracted or injuries sustained as a result of war, declared or undeclared, enemy action or action of the Armed Forces of the United States, or its allies, or while serving in the Armed Forces of any country; or any illness or injury occurring after the effective date of this Contract and caused by atomic explosion whether or not the result of war.

12. Reimbursement to the Participant or any dental office for the cost of Dental Services provided by Dentists other than the Primary Provider, unless expressly authorized in writing by the Primary Provider or due to an Emergency.

13. Out of Area Services, unless due to an Emergency and then covered only to the extent of the Emergency Service benefit shown in the Benefit Schedule.

14. Dental Service and Emergency Service received from a dental or medical department maintained on behalf of an employer, a mutual benefit association, a labor union, academic institution, trustee or similar person or group.

15. Replacement of an existing removable denture, full denture, crown or fixed bridge by a new removable partial denture, full denture, crown or a fixed bridge if the existing appliance was provided in the previous five years. The five-year period will be measured from the date on which the existing appliance was last supplied, whether under the Contract or under any other dental coverage.

16. If a satisfactory result can be achieved by a conventional removable partial denture in the case of bilateral edentulous areas, but the Participant selects a more complicated treatment (precision attachments or fixed bridgework), Benefits shall be limited to the appropriate procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost for the more elaborate selected procedure will be the responsibility of the Participant.

17. Services or supplies for personalization or characterization of dentures or bridges.

18. Crowns to restore diseased or broken teeth when the tooth can be restored by a conventional type filling.

19. Any expense arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:

    (a) Benefits are provided or payable under any Workers' Compensation, Employer Liability Law, or Occupational Disease Act or Law; or

    (b) You would have been eligible for benefits under any Workers' Compensation, Employer Liability Law or Occupational Disease Act or Law had You applied for such coverage;

20. Any service related to:

    (a) Altering vertical dimension;

    (b) Restoration of occlusion;

    (c) Splinting teeth including multiple abutments or any service to stabilize periodontally weakened teeth;

    (d) Replacing tooth structures as a result of abrasions, attrition, or erosion; or

    (e) Bite registration or bite analysis.

21. Missed appointment charges.

22. Removal of asymptomatic third molars (wisdom teeth).

23. Procedures done in conjunction with fixed complex implant retainer prosthetics.

TERMINATION

TERMINATION

For information about continuing coverage, contact Employee Insurance.

Service After Termination. Except as otherwise provided in the Contract, in the event any services are required by You or are performed on Your behalf after Your rights to Benefits have terminated, the expenses incurred for such care shall be Your full responsibility.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage within 31 days after the due date or

- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or

- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment; or

- The day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
- If You are temporarily absent from work due to an approved leave of absence for medical reasons, Your coverage under this Plan will continue during that leave for a maximum of 180 consecutive days.
- If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
- If You are temporarily absent from work due to non-medical or military duty reasons, You may continue Plan coverage through COBRA; or
- The day of the month in which Your employment ends; or

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

- The day of the month in which Your coverage ends except in the event that the Employee dies, coverage for the Dependent will continue for 90 days following the death of the Employee, after which time COBRA coverage will be offered, or, if employed by the Tribe, plan coverage; or

- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides. Failure to notify within 30 days will result in charges to the Employee for expenses paid on an ineligible member; or

- The day of the month in which Your Dependent Child attains the limiting age listed under the

- Eligibility section; or

- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled for employer health coverage;

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment; or

- Legal guardianship must be pursuant to an order by a court of competent jurisdiction and Plan coverage will terminate at age 18 unless Totally Disabled or meets the eligibility requirements in this Plan up to age 26;

- The day of the month in which the Dependent becomes covered as an Employee under this Plan.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment and You qualify for eligibility under this Plan again at a later date, You must meet all requirements of a new Employee.

If Your coverage ends due to leave of absence, reduction of hours or lay-off and You qualify for eligibility under this Plan again at a later date, You are eligible for coverage on the date You return to work. Contact Your Employee Benefits department for assistance with re-enrolling.

CONTINUATION OF COVERAGE

Federal law ("COBRA") allows You to continue coverage beyond the date coverage normally ends. The Contract complies with COBRA to the extent required by law.

The Group must determine whether COBRA applies to it. The Group must comply with COBRA requirements for employers and plan administrators.

You may elect COBRA if you are a Qualified Beneficiary and you lose coverage under this Plan due to a Qualifying Event. Your summary plan description contains a detailed description of the terms and conditions of COBRA coverage.

DISENROLLMENT

CARE-PLUS may disenroll You, resulting in termination of coverage, for any one of the reasons described below:

1. You fail to pay required premiums within 31 days after the due date.

2. You permit someone else to use the enrollment identification or knowingly provide fraudulent information in applying for coverage or receiving services.

3. You pose a threat to providers or other Members of the plan because of physical or verbal abuse.

4. You are unable to establish or maintain a satisfactory provider-patient relationship with a Primary Provider. Disenrollment only will occur after CARE-PLUS has provided You with an opportunity to select an alternate provider, has made reasonable efforts to assist You in establishing a satisfactory provider-patient relationship, and has provided You with notice of the right to file a Grievance.

5. You move outside the Service Area.

If You are disenrolled, You may appeal CARE-PLUS' decision by filing a Grievance. CARE-PLUS will arrange alternative dental coverage for You if You are disenrolled until the earlier of: (a) the date You find alternative coverage, or (b) the date You have an opportunity to change plans.

CLAIM RULES

1. **Definitions**.

   "Pre-service claim" is a claim for which approval is required before receipt of care.

   "Urgent care claim" is a claim where waiting the standard time for a benefit decision could seriously jeopardize Your life, health or ability to regain maximum function or in the opinion of a physician with knowledge of Your condition, would subject You to severe pain that cannot be adequately managed without the care requested.

   "Post-service claim" is a claim for payment or reimbursement after receipt of care.

2. **Proof of Loss.** You must give us written proof of a loss with a claim. This proof must cover the occurrence, character and extent of the loss. You must furnish proof within ninety (90) days after the date of the loss. Claims furnished after ninety (90) days will not be considered valid. However, if it is not reasonably possible to meet such time limit, the claim will still be considered valid if the proof is furnished as soon as reasonably possible.

   If You fail to properly follow our procedure for filing a pre-service claim, we will notify You within five (5) days of the proper procedure. If the claim is an urgent care claim, we will notify You within twenty-four (24) hours.

3. **Initial Determinations.**

   a. Urgent Care Claims.

      If Your claim is an urgent care claim, we will provide You with a decision as soon as possible, taking into account Your medical circumstances. We will make a decision no later than seventy-two (72) hours after receipt of Your claim. However, if we require additional information from You to make the benefit determination, we will make such a request within twenty-four (24) hours of receipt of Your claim. You will have a reasonable amount of time to provide the information taking into account Your medical circumstances. Reasonable means not less than forty-eight (48) hours. We will reach a decision as soon as possible, but not later than forty-eight (48) hours from:

      (1) The receipt of the additional information from You, or

      (2) The end of the time period You had to provide the information

      whichever occurs first. If we orally deny Your claim, You will receive a written notice within three (3) days. Our denial will include all the elements listed in part d.

   b. Concurrent Care Decisions.

      We may approve an ongoing course of treatment to be provided over a period of time or a number of treatments.

      If we have approved an ongoing course of treatment and we determine that such treatment should be reduced or terminated before the end of the period of time or number of treatments authorized, we will inform You enough time in advance of the reduction or termination to appeal our decision before we reduce or terminate such treatment. The notice will include all the

elements listed in part d. If Your appeal to continue treatment is an urgent care claim, we will make a determination as soon as possible, taking into account Your medical circumstances. We will make a decision no later than twenty-four (24) hours after receipt of Your appeal.

c. Other Claims.

All other initial determinations will be made within the following timeframes:

(1) Pre-service claims: Within a reasonable amount of time appropriate to the medical circumstances but not later than fifteen (15) days after the date the claim was received by us.

(2) Post-service claims: Within a reasonable period of time, but not later than thirty (30) days after the date the claim was received by us.

If we determine that we will not be able to meet the above deadline, for reasons beyond our control, we will notify You in writing prior to the expiration of the initial deadline. The notice will state the reason for the delay and the date on which You can expect a decision. The expected decision date will not be more than fifteen (15) days from the original deadline. However, if we require additional information from You to make the benefit determination, the expected decision date will be not more than fifteen (15) days from the date You respond to the request for additional information. The notice will specifically describe the additional information required. You will have forty-five (45) days from the date You receive the notice to provide the additional information.

d. Claim Denials.

If we deny Your claim, in whole or in part, we will inform You in writing. The denial notice will include all of the following:

(1) The specific reason(s) for the denial.

(2) Reference to the specific plan provision on which the denial is based.

(3) A description of any additional information needed to complete the claim and an explanation of why the information is necessary.

(4) A description of Your right to appeal, including the deadline and procedures, and Your right to bring a civil action under the Employee Retirement Security Income Act of 1974, as amended, ("ERISA") section 502(a) if the appeal is not decided in Your favor.

(5) If we used a specific internal guideline to make our determination, a statement that we relied on such guideline and that You may obtain a copy of the guideline free of charge, upon request.

(6) If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

(7) If Your claim involves urgent care, a description of our expedited review process.

e. Appeal of Claim Denials. You have one hundred eighty (180) days after You receive a notice described in part d above to appeal a claim denial. You appeal a claim denial by following the Grievance Procedure explained below.

4. **Grievance Procedure.**

You will be notified of Your right to file a Grievance and the procedure to follow each time a claim or benefit is denied. This includes a refusal to refer You for additional services, or when disenrollment proceedings are initiated. The notification will state the specific reason for the denial or initiation of disenrollment proceedings. The Grievance procedure is outlined below.

In the event that You have a complaint or problem regarding services under the Contract, You should submit Your Grievance in written form to CARE-PLUS' Grievance committee. The Grievance committee will acknowledge the Grievance in writing within five (5) business days of receipt.

If Your Grievance is an appeal of an urgent care claim, You may request an expedited Grievance. You should call 1-414-771-1711 or 1-800-318-7007 and state that You would like an expedited Grievance.

You have the following rights with respect to Your Grievance:

a. The right to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

b. The right to submit written comments, documents, records and other information relating to Your claim.

c. The right to appear before the Grievance committee to present written or oral information and to question the person who made the initial determination that resulted in the Grievance. The Grievance committee shall notify You of the date and time of the committee meeting at least seven (7) calendar days before the meeting is scheduled.

The Grievance committee will conduct a complete, new review of Your claim, without considering the initial determination. The committee will not include the person who originally denied the claim or that person's subordinate. If the claim requires a medical judgment, the committee will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. If a health care professional was consulted in making the initial determination, the health care professional consulted on appeal will not be the same person or that person's subordinate. Upon request, we will provide You with the names of the medical or vocational experts consulted to reach a determination.

The Grievance committee will provide You with a written decision within the following timeframes:

a. Urgent care claim: As quickly as Your condition requires, but no later than within seventy-two (72) hours of receipt of the Grievance.

b. Pre-service claim: Within thirty (30) days of the date we originally received the Grievance.

c. Post-service claim: Within thirty (30) days of the date we originally received the Grievance.

The committee's written decision will notify You of the result of Your Grievance and any corrective action taken. The decision will be signed by a member of the committee and include the position titles of the committee members.

If the Grievance committee denies Your appeal, in whole or in part, the written decision will include all of the following:

a. The specific reason(s) for the denial.

b. Reference to the specific plan provision on which the denial is based.

c. A statement that You are entitled to access all documents, records and other information relevant to Your claim and receive a copy of such information free of charge, upon request.

d. A statement of Your right to bring a civil action under ERISA section 502(a).

e. If the Grievance committee used a specific internal guideline to make the determination, a statement that it relied on such guideline and that You may obtain a copy of such guideline free of charge, upon request.

f. If the determination is based on a medical determination, such as that the procedure is not medically necessary or is experimental, a statement that, upon request and free of charge, an explanation will be provided of the scientific or clinical judgment for the determination as applied to Your medical condition.

You may resolve the Grievance by taking the steps outlined above. You also may contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency that enforces Wisconsin's insurance laws, and file a complaint. You can contact the **Office of the Commissioner of Insurance** by writing to:

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

Or You can call 1-800-236-8517 outside of Madison or 1-608-266-0103 in Madison, and request a complaint form.

5. **Authorized Representative.**

Your authorized representative may act on Your behalf in pursuing a claim or Grievance. Unless one of the exceptions listed below applies, You must submit a statement in writing that the representative is authorized to act on Your behalf and may receive Your confidential information. We have a form available that You may use to appoint an individual as Your authorized representative.

We will not require written authorization if any of the following applies:

a. The person is authorized by law to act on Your behalf.

b. You are unable to give consent and the person is a spouse, family member or the treating provider.

c. The Grievance is an expedited Grievance and the person represents that You have verbally authorized the person to represent You.

GENERAL CONDITIONS

1. **Dentist/Participant Relationship**. Nothing in the Contract shall interfere with the professional relationship between You and Your attending Dentist.

2. **Evidence of Participation**. You must present Your identification card, or otherwise make the fact of Your participation known, to the Group Dentist when applying for Benefits.

3. **Release of Information**. You expressly consent to, authorize and direct any Dentist or other person or corporation by whom or in which dental, medical or surgical treatment is being considered or has been rendered, to release any records or other information, or copies thereof, as CARE-PLUS may request.

4. **Subrogation**. Whenever CARE-PLUS has been or is providing Benefits because of an injury or sickness for which a third party may be liable, CARE-PLUS may make a claim or maintain an action against the third party for damages, reimbursement or payment to the extent of the value of Benefits received or to be received.

   By accepting Benefits from CARE-PLUS relating to an injury or sickness, You assign to CARE-PLUS the right to make a claim against the third party to the extent of the value of Benefits rendered.

   You and CARE-PLUS agree to join the other in making a claim against the third party or commencing an action.

   To the extent required by law, CARE-PLUS shall seek to recover proceeds from You only after You have been wholly or fully compensated for the damages arising from the injury or sickness. CARE-PLUS shall have an equitable lien that shall attach to any recovery to the extent of its subrogation rights. You shall hold in trust for CARE-PLUS any proceeds recovered to the extent of its subrogation rights.

   You must not do anything after the loss to prejudice any rights of CARE-PLUS or of the Group to recovery. You must promptly advise CARE-PLUS and the Group in writing whenever a claim against a third party is made with respect to any loss for which Benefits were, or are being, received from CARE-PLUS.

   Nothing contained in this section shall limit the ability or right of the Group to make a claim or maintain an action against the third party for recovery.

5. **Monetary Value of Benefits**. When it is necessary to determine the monetary value of Benefits provided to You under the Contract, such value shall be the charges that would have been made if the Contract were not in effect.

6. **Non-Assignment of Benefits**. No person other than You is entitled to Benefits under this Contract. Rights under this Contract are not assignable or transferable in any manner. Rights shall be forfeited if You or any other person assigns, transfers or aids any other person improperly in obtaining Benefits hereunder.

7. **Limitation of Actions**. You may not start an action or suit, at law or in equity, to recover Benefits under the Contract until at least sixty (60) days after a claim has been filed with CARE-PLUS in writing or CARE-PLUS denies the claim, whichever is earlier. No action shall be commenced more than three years from the time the written proof of loss is required to be furnished to CARE-PLUS.

8. **Obligation of CARE-PLUS**. CARE-PLUS shall in no way be responsible for any act or omission of any Primary Provider, Group Dentist, professional practitioner or their agents, to supply Dental Services. The obligation of CARE-PLUS shall be limited solely to providing Benefits according to the provisions in the Contract.

9. **Reimbursement**. You agree to reimburse CARE-PLUS for any Benefits paid or provided for which You were not eligible under the terms of the Contract. Such reimbursement shall be due and payable immediately upon notification and demand to You by CARE-PLUS.

10. **Misrepresentations**. Fraudulent misstatements by You shall void Your coverage and serve as the basis for denials of claims for Benefits.

11. **Dual Coverage**. If You are eligible for Benefits under more than one CARE-PLUS Contract, You shall be entitled to an allowance therefore equal to the Charges for the aggregate Benefits available under such CARE-PLUS Contracts, up to, but not exceeding, the total incurred regular Charges for all Dental Services.

COORDINATION OF BENEFITS

1. APPLICABILITY. This Coordination of Benefits ("COB") provision applies to This Plan when a Participant has health care coverage under more than one Plan. However, this provision may be superseded by the Medicare secondary payor rules. "Plan" and "This Plan" are defined below.

   If this COB provision applies, the order of benefit determination rules shall be looked at first. The rules determine whether the Benefits of This Plan are determined before or after those of another Plan. The Benefits of This Plan:

   a. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its Benefits before another Plan; but

   b. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in the section "Effect on the Benefits of This Plan."

2. DEFINITIONS.

   a. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care. Allowable Expense includes Dental Services and Orthodontic Services, when the item of expense is covered at least in part by one or more Plans covering the claimant. When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit paid.

   b. "Claim Determination Period" means a Calendar Year. However, it does not include any part of a year during which a person has no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

   c. "Plan" means any of the following that provides benefits or services for, or because of, medical or dental care or treatment:

      (1) Group insurance or group-type coverage, whether insured or uninsured, that includes continuous 24-hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

      (2) Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid. It also does not include any plan whose benefits, by law, are excess to those of any private insurance program or other non-

governmental program. Each contract or other arrangement for coverage under (1) or (2) is a separate Plan. If an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

d. "Primary Plan"/"Secondary Plan". The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When This Plan is a Secondary Plan, its Benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its Benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more other Plans and may be a Secondary Plan as to a different Plan or Plans.

e. "This Plan" means the part of the Group Contract that provides Benefits for Dental Service expenses.

3. ORDER OF BENEFIT DETERMINATION. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan that has its Benefits determined after those of the other Plan, unless:

a. The other Plan has rules coordinating its benefits with those of This Plan; and

b. Both those rules and This Plan's rules described below require that This Plan's Benefits be determined before those of the other Plan.

4. RULES. This Plan determines its order of benefits using the first of the following rules that applies:

a. Non-dependent/Dependent. The benefits of the Plan that covers the person other than as a Dependent are determined before those of the Plan that covers the person as a Dependent.

b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph c., when This Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

(1) The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (1) but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;

(2) Then, the Plan of the spouse of the parent with the custody of the child; and

(3) Finally, the Plan of the parent not having custody of the child.

Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule b. above.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. Active/Inactive Employee. The benefits of a Plan that covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a Plan that covers that person as a laid off or retired employee or as that employee's dependent. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule d. is ignored.

e. Continuation Coverage. If a person has continuation coverage under federal or state law and is also covered under another plan, the following shall determine the order of benefits:

(1) First, the benefits of a plan covering the person as an employee, member or subscriber or as a dependent of an employee, member or subscriber.

(2) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this paragraph e. is ignored.

f. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan that covered an employee, member or subscriber longer are determined before those of the Plan that covered that person for the shorter time.

5. EFFECT ON THE BENEFITS OF THIS PLAN.

a. When This Section Applies. This Section applies when, in accordance with the Section "Order of Benefit Determination", This Plan is a Secondary Plan as to one or more other Plans. In that event the Benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" below.

b. Reduction in This Plan's Benefits. The Benefits of This Plan will be reduced when the sum of the following exceeds the Allowable Expenses in a Claim Determination Period:

(1) The Benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

(2) The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made. Under this provision, the Benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

6. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION. CARE-PLUS has the right to decide the facts it needs to apply these COB rules. It may get needed facts from or give them to any other organization or person without the consent of the insured but only as needed to apply these COB rules. Medical records remain confidential as provided by state law. Each person claiming Benefits under This Plan must give CARE-PLUS any facts it needs to pay the claim.

7. FACILITY OF PAYMENT. A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, CARE-PLUS may pay that amount to the organization that made that payment. That amount will then be treated as though it was a Benefit paid under This Plan. CARE-PLUS will not have to pay that amount again. The term "payment made" means reasonable cash value of the Benefits provided in the form of services.

8. RIGHT OF RECOVERY. If the amount of the payments made by CARE-PLUS is more than it should have paid under this COB provision, it may recover the excess from one or more of:

   a. The persons it has paid or for whom it has paid;

   b. Insurance companies; or

   c. Other organizations.

   The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

For further information, contact:

CARE-PLUS Dental Plans, Inc.
3333 N. Mayfair Rd., Suite 311
Wauwatosa, Wisconsin 53222
(414) 771-1711
(800) 318-7007

ADDENDUM A
PLAN BENEFIT SCHEDULE
FOR
ONEIDA NATION
GROUP NO. PPD185

1. COVERED DENTAL SERVICES. Except as otherwise specified in this Contract, Participants are entitled to any of the Dental Services listed that begin on or after their Effective Date of coverage. Such Dental Services are to be consistent with and necessary, according to accepted standards of good dental practice, for the diagnosis and treatment of the Participant and must not be performed primarily for cosmetic purposes.

2. ANNUAL MAXIMUM BENEFITS. The Annual Maximum Benefit for Dental Services, except orthodontic services, is

   a. $2,000.00 per eligible Participant;

3. ORTHODONTIC SERVICES. Benefits for a complete routine orthodontic case shall:

   a. Be available to eligible Participants to include adults;

   b. Be subject to a copayment of 50% of the Group Dentist's fees to be paid by the Participant; and

   c. Be subject to a lifetime maximum benefit of $2,000.00.

   A routine orthodontic case is one in which alignment of the teeth is accomplished using a single phase of treatment with complete braces and a single set of retainers. Additional costs are incurred when treatment requires auxiliary fixed or removable appliance therapy, such as the use of functional jaw orthopedic appliances; treatment of impacted teeth/tooth; cleft palate; orthognathic surgery procedures; or use of ceramic braces or other specialized braces other than stainless steel that the patient may require or request for specific reasons.

   Each Participant eligible under a. shall be entitled to one complete course of orthodontic treatment while the Contract is in force.

   Orthodontic Benefits including surgical and appliance therapy will only be provided when, in the opinion of the orthodontist, treatment is necessary, and a satisfactory result can be achieved.

   Orthodontic benefits will terminate when a Participant ceases to be eligible for coverage, i.e. age limitations for orthodontic treatment or termination of the Contract by the Group or CARE-PLUS for any reason.

   Cross bite in permanent teeth will only be treated when, in the opinion of the orthodontist, other conditions are present that would indicate that orthodontic treatment is necessary.

   If the orthodontic treatment is terminated for any reason before completion, the obligation of CARE-PLUS to provide Benefits shall cease as of such date of termination. If such orthodontic treatment is resumed, Benefits shall resume, to the extent remaining under this Contract.

4. LABORATORY CHARGES. Except as otherwise provided, the Participant will not be liable for Laboratory Charges.

5. EMERGENCY SERVICE. Emergency Service includes Dental Service that is required immediately as a result of an accident or Emergency illness. Emergency Service does not include Dental Service for elective care or care required as a result of circumstances or conditions that could reasonably have been foreseen.

   a. There will be a Group Dentist on call for non-clinic hours to attend to the Participant's Emergency needs within the Service Area.

   b. Participants who receive Emergency Service outside the Service Area, shall be entitled to Benefits for Dental Service not to exceed the lesser of the Charges directly related to Emergency Service or $80.00 per Participant (the maximum allowance). Proof of Emergency Service must be given to the Participant's Group Dentist or CARE-PLUS within thirty (30) days of date of occurrence.

6. DENTAL SERVICES PROVIDED TO THE GROUP. See Addendum B

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D0120	Periodic oral examination – 2 per year –frequency rules apply	NONE
D0140	Limited oral evaluation – problem focus – frequency rules apply	NONE
D0145	Oral evaluation for patient <3 years w/counseling w/primary caregiver – frequency rules apply	NONE
D0150	Comprehensive oral evaluation – frequency rules apply	NONE
D0210	Intraoral-complete series of radiographic images w/bitewings	NONE
D0220	Intraoral-periapical-first radiographic image	NONE
D0230	Intraoral-periapical-each additional radiographic image	NONE
D0240	Intraoral – occusal radiographic image	NONE
D0270	Bitewing-single radiographic image	NONE
D0272	Bitewing-two radiographic images – 2 per year	NONE
D0274	Bitewing-four radiographic images – 2 per year	NONE
D0330	Panoramic radiographic image	NONE
D0460	Pulp vitality tests	NONE
D0470	Diagnostic casts	NONE
PREVENTATIVE		
D1110	Prophylaxis-adult – 2 per year	NONE
D1120	Prophylaxis-child – 2 per year	NONE
D1206	Topical application of fluoride varnish – thru age 15	NONE
D1208	Topical application of fluoride – excluding varnish – thru age 15	NONE
D1310	Nutritional counseling for control of dental disease	NONE
D1330	Oral hygiene instructions	NONE
D1351	Sealant per tooth – thru age 15	NONE
D1353	Sealant repair – per tooth – thru age 15	NONE
D1354	Interim caries arresting medicament application – thru age 12	NONE
D1510	Space maintainer – fixed – unilateral	NONE
D1515	Space maintainer – fixed – bilateral	NONE
D1550	Re-cement/re-bond space maintainer	NONE
RESTORATIVE		
D2140	Amalgam – one surface, primary or permanent	NONE
D2150	Amalgam – two surfaces, primary or permanent	NONE
D2160	Amalgam – three surfaces, primary or permanent	NONE
D2161	Amalgam – four or more surfaces, primary or permanent	NONE
D2330	Resin-based composite – one surface, anterior	NONE
D2331	Resin-based composite – two surfaces, anterior	NONE
D2332	Resin-based composite – three surfaces, anterior	NONE
D2335	Resin-based composite – four or more surfaces, anterior incisal angle	NONE
D2390	Resin-based composite crown, anterior	NONE
D2391	Resin-based composite – one surface, posterior	NONE
D2392	Resin-based composite – two surfaces, posterior	NONE
D2393	Resin-based composite – three surfaces, posterior	NONE
D2394	Resin-based composite – four or more surfaces, posterior	NONE
D2740	Crown – porcelain/ceramic substrate	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D2752	Crown – porcelain fused to noble metal	NONE
D2792	Crown – full cast noble metal	NONE
D2910	Re-cement or re-bond inlay, onlay, veneer	NONE
D2920	Re-cement or re-bond crown	NONE
D2921	Reattachment of tooth fragment – incisal edge/cusp	NONE
D2929	Prefabricated porcelain/ceramic crown – primary tooth	NONE
D2930	Prefabricated stainless steel crown – primary tooth	NONE
D2931	Prefabricated stainless steel crown – permanent tooth	NONE
D2932	Prefabricated resin crown	NONE
D2933	Prefabricated stainless steel crown w/resin window	NONE
D2934	Prefabricated esthetic coasted stainless steel crown – primary tooth	NONE
D2940	Protective restoration	NONE
D2949	Restorative foundation for an indirect restoration	NONE
D2950	Core build-up including pins when required	NONE
D2951	Pin retention/tooth in addition to restoration	NONE
D2952	Post and core in addition to crown indirectly fabricated	NONE
D2954	Prefabricated post and core in addition to crown	NONE
D2955	Post removal	NONE
D2960	Labial veneer resin (laminate) chairside	NONE
D2980	Crown repair necessitated by restorative material failure	NONE
ENDODONTICS		
D3110	Pulp cap – direct excluding final restoration	NONE
D3120	Pulp cap – indirect excluding final restoration	NONE
D3220	Therapeutic pulpotomy excluding final restoration	NONE
D3221	Pulpal debridement, primary and permanent tooth	NONE
D3230	Pulpal therapy, anterior primary tooth	NONE
D3240	Pulpal therapy, posterior primary tooth	NONE
D3310	Endodontic therapy anterior tooth	NONE
D3320	Endodontic therapy bicuspid tooth	NONE
D3330	Endodontic therapy molar tooth	NONE
D3332	Incomplete endodontic therapy procedure	NONE
D3346	Retreatment of previous root canal – anterior	NONE
D3347	Retreatment of previous root canal – bicuspid	NONE
D3348	Retreatment of previous root canal – molar	NONE
D3351	Apexification/recalcification – initial visit. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3352	Apexification/recalcification – interim medication replacement. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3353	Apexification/recalcification – final visit. If over age 11 no benefit if performed within 12 months of root canal.	NONE
D3410	Apicoectomy – anterior	NONE
D3421	Apicoectomy – bicuspid (first root)	NONE
D3425	Apicoectomy – molar (first root)	NONE
D3426	Apicoectomy (each additional root)	NONE
D3430	Retrograde filling – per root	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D3450	Root amputation – per root	NONE
D3920	Hemisection not including root canal therapy	NONE
D3950	Canal preparation and fitting of preformed dowel or post	NONE
PERIODONTICS		
D0180	Comprehensive periodontic evaluation – frequency rules apply	NONE
D4210	Gingivectomy/gingivoplasty/four or more teeth per quadrant	NONE
D4211	Gingivectomy/gingivoplasty/one to three teeth per quadrant	NONE
D4231	Anatomical crown exposure – one to three teeth per quadrant	NONE
D4240	Gingival flap procedure w/root plan/four or more teeth per quadrant	NONE
D4241	Gingival flap procedure w/root plan/one to three teeth per quadrant	NONE
D4249	Clinical crown lengthening – hard tissue	NONE
D4260	Osseous surgery – four or more teeth per quadrant	NONE
D4261	Osseous surgery – one to three teeth per quadrant	NONE
D4263	Bone replacement graft – first site in quadrant	NONE
D4264	Bone replacement graft – each additional site in quadrant	NONE
D4266	Guided tissue regeneration – resorbable barrier, per site	NONE
D4267	Guided tissue regeneration – nonresorbable barrier, per site	NONE
D4270	Pedicle soft tissue graft procedure	NONE
D4273	Subepithelial connective tissue graft procedures, per tooth	NONE
D4274	Distal or proximal wedge procedure	NONE
D4275	Soft tissue allograft	NONE
D4277	Free soft tissue graft procedure first tooth position	NONE
D4278	Free soft tissue graft procedure each additional tooth position	NONE
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	NONE
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	NONE
D4320	Provisional splinting – intracoronal	NONE
D4321	Provisional splinting – extracoronal	NONE
D4341	Scaling and root planing/four or more teeth per quadrant – one per 24 mo.	NONE
D4342	Scaling and root planing/one to three teeth per quadrant – one per 24 mo.	NONE
D4355	Full mouth debridement – one per 18 mo.	NONE
D4381	Localized delivery of chemo agents	NONE
D4910	Periodontal maintenance procedure – one per 12 mo. only	NONE
PROSTHODONTICS, REMOVABLE		
D5110	Complete denture – maxillary	NONE
D5120	Complete denture – mandibular	NONE
D5130	Immediate denture – maxillary	NONE
D5140	Immediate denture – mandibular	NONE
D5211	Maxillary partial denture – resin base	NONE
D5212	Mandibular partial denture – resin base	NONE
D5213	Maxillary partial denture – cast metal frame	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D5214	Mandibular partial denture – cast metal frame	NONE
D5221	Immediate maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	NONE
D5222	Immediate mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	NONE
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	NONE
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	NONE
D5225	Maxillary partial denture – flexible base	NONE
D5226	Mandibular partial denture – flexible base	NONE
D5281	Removable unilateral partial denture	NONE
D5410	Adjust complete denture – maxillary	NONE
D5411	Adjust complete denture – mandibular	NONE
D5421	Adjust partial denture – maxillary	NONE
D5422	Adjust partial denture – mandibular	NONE
D5510	Repair broken denture	NONE
D5520	Replace missing/broken teeth – complete denture each tooth	NONE
D5610	Repair resin denture base	NONE
D5620	Repair cast framework	NONE
D5630	Repair or replace broken clasp	NONE
D5640	Replace broken teeth – per tooth	NONE
D5650	Add tooth to existing partial denture	NONE
D5660	Add clasp to existing partial denture	NONE
D5730	Reline complete maxillary denture (chairside)	NONE
D5731	Reline complete mandibular denture (chairside)	NONE
D5740	Reline maxillary partial denture (chairside)	NONE
D5741	Reline mandibular partial denture (chairside)	NONE
D5750	Reline complete maxillary denture (lab)	NONE
D5751	Reline complete mandibular denture (lab)	NONE
D5760	Reline maxillary partial denture (lab)	NONE
D5761	Reline mandibular partial denture (lab)	NONE
D5850	Tissue conditioning, maxillary	NONE
D5851	Tissue conditioning, mandibular	NONE
D5899	CU-SEL attachment	NONE
D5899	Silicone soft liner	NONE
PROSTHODONTICS, FIXED		
D6212	Pontic – cast noble metal	NONE
D6242	Pontic – porcelain fused to noble metal	NONE
D6245	Pontic – porcelain/ceramic	NONE
D6740	Crown – porcelain/ceramic	NONE
D6752	Crown – porcelain fused to noble metal	NONE
D6792	Crown – full cast noble metal	NONE
D6930	Re-cement or re-bond fixed partial denture	NONE
D6940	Stress breaker	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D6980	Fixed partial denture repair necessitated by material failure	NONE
IMPLANTS		
D6010	Surgical placement – endosteal , as indicated in article VII, procedures done in conjunction with fixed complex implant retainer prosthetics are not included	20%
D6056	Prefabricated abutment	20%
D6057	Custom fabricated abutment	20%
D6058	Abutment supported porcelain/ceramic crown	20%
D6061	Abutment supported porcelain fused to metal crown (noble metal)	20%
D6064	Abutment supported cast metal crown (noble metal)	20%
D6065	Implant supported porcelain/ceramic crown	20%
D6068	Abutment supported retainer for porcelain/ceramic fpd	20%
D6071	Abutment supported retainer for porcelain fused to metal fpd (noble metal)	20%
D6074	Abutment supported retainer for cast metal fpd (noble metal)	20%
D6075	Implant supported retainer for ceramic fpd	20%
D6080	Implant maintenance procedures	20%
D6092	Re-cement or re-bond implant/abutment supported crown	20%
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	20%
D6100	Implant removal, by report	20%
D6110	Implant/abutment supported removable denture for edentulous arch-maxillary	20%
D6111	Implant abutment supported removable denture for edentulous arch-mandibular	20%
D6112	Implant/abutment supported removable denture for partially edentulous arch-maxillary	20%
D6113	Implant/abutment supported removable denture for partially edentulous arch-mandibular	20%
ORAL SURGERY		
D7111	Extraction, coronal remnants – deciduous tooth	NONE
D7140	Extraction, erupted tooth or exposed root	NONE
D7210	Surgical removal of erupted tooth	NONE
D7220	Removal of impacted tooth – soft tissue	NONE
D7230	Removal of impacted tooth – partial bony	NONE
D7240	Removal of impacted tooth – complete bony	NONE
D7241	Removal of impacted tooth – complete bony w/unusual surg. complications	NONE
D7250	Surgical removal of residual tooth roots	NONE
D7260	Oroantral fistula closure	NONE
D7270	Tooth reimplantation and/or stabilization	NONE
D7280	Surgical access of an unerupted tooth	NONE
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	NONE
D7283	Placement of device to facilitate eruption of impacted tooth	NONE
D7285	Incisional biopsy of oral tissue – hard	NONE
D7286	Incisional biopsy of oral tissue – soft	NONE
D7288	Brush biopsy	NONE
D7291	Transeptal fiberotomy	NONE

ADDENDUM B
PROCEDURE DESCRIPTION
FOR
ONEIDA NATION, GROUP NO. PPD185

When a Participant is under the care or treatment of a Primary Provider, Benefits include the following dental services unless the benefit is specifically excluded under Exclusions and Limitations:

ADA CODE	DESCRIPTION	PARTICIPANT'S CO-PAYMENT
D7310	Alveoloplasty in conjunction w/extractions – four or more teeth per quad	NONE
D7311	Alveoloplasty in conjunction w/extractions – one to three teeth per quad	NONE
D7320	Alveoloplasty not in conjunction w/extractions – four or more teeth per quad	NONE
D7321	Alveoloplasty not in conjunction w/extractions – one to three teeth per quad	NONE
D7340	Vestibuloplasty-ridge extension	NONE
D7471	Removal of lateral (maxilla or mandible) exostosis	NONE
D7472	Removal of torus palatinus	NONE
D7473	Removal of torus mandibularis	NONE
D7485	Surgical reduction of osseous tuberosity	NONE
D7510	Incision and drainage abscess – intraoral soft tissue	NONE
D7910	Suture of recent small wound up to 5 cm	NONE
D7953	Bone replacement graft for ridge preservation – per site	NONE
D7960	Frenulectomy – separate procedure	NONE
D7970	Excision of hyperplastic tissue per arch	NONE
D7971	Excision of pericoronal gingiva	NONE
D7972	Surgical reduction of fibrous tuberosity	NONE
ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment dental pain – minor procedure	NONE
D9210	Local anesthesia not in conjunction with operative or surgical procedures	NONE
D9215	Local anesthesia in conjunction with operative or surgical procedures	NONE
D9219	Eval for deep sedation or general anesthesia (frequency with exams)	NONE
D9223	Deep sedation/general anesthesia – each 15 minute increment	NONE
D9230	Inhalation of nitrous oxide/analgesia – DDS required	NONE
D9243	Intravenous moderate (conscience) sedation/analgesia – each 15 minute increment	NONE
D9310	Consultation – per session - frequency rules apply	NONE
D9430	Office visit for observation (during regularly scheduled hours)	NONE
D9630	Other drugs and/or medicaments	NONE
D9910	Application of desensitizing medicaments (dispensed in office)	NONE
D9951	Occlusal adjustment – limited	NONE

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

AMENDATORY ENDORSEMENT

ONEIDA NATION
GROUP NO. PPD185

This amendatory endorsement modifies insurance provided to ONEIDA NATION under your CARE-PLUS DENTAL PLANS, INC., DENTAL CARE GROUP POLICY/CERTIFICATE. This amendatory endorsement is attached to and made part of the Policy/Certificate. Except as stated herein, this Amendatory Endorsement does not change coverage in any other way and is subject to all provisions, terms, and conditions of the Policy/Certificate. If there is a conflict between the Policy/Certificate and this Amendatory Endorsement, the terms of this Amendatory Endorsement will govern.

The following additional benefits for evidence-based integrated care are added to this policy effective January 1, 2017:

1. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year following periodontal surgery.

2. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for diabetics.

3. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to one time per benefit year during pregnancy.

4. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for patients with any of the following high–risk cardiac conditions.
   - History of infective endocarditis.
   - Certain congenital heart defects (e.g., having one ventricle instead of two).
   - Artificial heart valves.
   - Heart-valve defects caused by acquired conditions like rheumatic heart disease.
   - Hypertrophic cardiomyopathy, which causes abnormal thickening of the heart muscle.
   - Individuals with pulmonary shunts or conduits.
   - Mitral-valve prolapse with regurgitation (blood leakage).

5. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for suppressed-immune-system conditions.

6. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times per benefit year for kidney failure or dialysis conditions.

7. Routine prophylaxis (teeth cleaning) or periodontal maintenance procedure up to two times and a topical fluoride application beyond the age limitation of the group contract per benefit year for cancer related chemotherapy and/or radiation treatments.