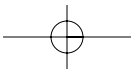
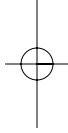
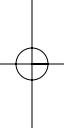




# **Midwestern Dental Plans**

**Building Solid Foundations  
for Good Dental Health**





## **MIDWESTERN DENTAL PLANS**

### **Group Member Certificate**

#### **General Provisions**

This Group Member Certificate is issued by Midwestern Dental Plans, Inc. (MDPI) to persons who have enrolled as Plan Members. By enrolling in this PLAN and accepting this Member Certificate, the Plan Member agrees to abide by the rules of the PLAN as outlined in this Member Certificate and recognizes that, except for emergency dental services, only those dental services provided or authorized by the PLAN are a benefit under this Member Certificate. Plan Members are entitled to the dental maintenance organization services and benefits described in the Member Certificate in exchange for Premium paid to the PLAN.

The terms outlined in the Group Dental Service Agreement take precedence over the conditions set forth in the Member Certificate.

## Article I

### Definitions

- A. **"ELIGIBLE MEMBER"** shall mean a bona fide member, an active employee, a retiree or other member of the Group who meets the eligibility requirements of the Group and the Member Certificate.
- B. **"ENROLLED MEMBER"** shall mean an Eligible Member for whom eligibility information and Premium payment have been received by the PLAN.
- C. **"DEPENDENT"** shall mean the legal spouse of an Enrolled Member, and/or the unmarried children of an Enrolled Member, whether natural or adopted. However, any such Dependent shall be deemed a Plan Member only if the individual meets the Group's eligibility requirements for Dependent coverage and for whom eligibility information and Premium payment have been received by the PLAN.
- D. **"PLAN MEMBER"** shall mean an Enrolled Member and enrolled Dependents for whom eligibility information and Premium payment have been received by the PLAN.
- E. **"PARTICIPATING DENTIST"** shall mean a dentist duly licensed by the State of Michigan who is under contract with the PLAN to provide dental services to Plan Members.
- F. **"BENEFITS OR SCHEDULE OF BENEFITS"** shall mean those dental services and benefits to the extent (and for the Co-Payments, if any) provided for in the PLAN, annexed hereto and made a part hereof as the Schedule of Benefits.
- G. **"GROUP"** shall mean the legal entity which has contracted with the PLAN on behalf of its Eligible Members for the Benefits described in this Dental Services Agreement.
- H. **"DENTAL SERVICES AGREEMENT"** shall mean that executed agreement between the PLAN and the Group.
- I. **"MEMBER CERTIFICATE"** shall mean the general provisions and Schedule of Benefits and any riders to it.
- J. **"PREMIUM"** shall mean the amount of money paid monthly including Enrolled Member contributions if any, on behalf of the Plan Members enrolled through the Group.

- K. **"SERVICE AREA"** shall mean the geographical area approved by state authorities which is served by the PLAN.
- L. **"AUTHORIZED OR COVERED DENTAL SERVICE"** shall mean any dental service which is a Benefit under the Certificate and which has been authorized by a Participating Dentist. All covered services must be rendered by a Participating Dentist unless a Referral Dentist has been approved to perform an authorized service by the PLAN.
- M. **"CO-PAYMENT"** shall mean the amount that the Plan Member is obligated to pay the PLAN for a specified Benefit.
- N. **"OUT-OF-AREA EMERGENCY"** shall mean where Benefits are required unexpectedly or immediately in order to alleviate pain and suffering when the Plan Member is temporarily more than fifty (50) miles from a Dental Center. A Plan Member will not be deemed to be temporarily out of area if more than fifty (50) miles from the Dental Center due to a regularly scheduled absence or due to absences associated with commuting more than fifty (50) miles to work.
- O. **"DENTAL CENTER"** shall mean a dental facility operated by or contracted with the PLAN.
- P. **"OPEN ENROLLMENT PERIOD"** shall mean a period of time at least once each calendar year agreed upon by the PLAN and the Group when Eligible Members within the Group are given the opportunity to enroll or disenroll in the PLAN.
- Q. **"REFERRAL DENTIST"** shall mean a non-participating dentist to whom a Plan Member is referred to by the PLAN.
- R. **"APPLICATION"** shall mean the completed enrollment form submitted to the Group or PLAN which lists the Plan Members who are enrolling.
- S. **"COBRA"** shall mean the Consolidated Omnibus Budget Reconciliation Act of 1986.

## Article II

### A. DENTAL SERVICES

The PLAN promises, covenants and agrees with the Group to provide the Benefits to Plan Members. All dental services shall be performed by persons duly licensed by the State of Michigan acting within the scope of their permitted

functions. No professional services shall be rendered except by persons acting under the direct supervision of a Participating Dentist present on the premises when such services are being performed.

**B. OTHER OBLIGATIONS OF THE PLAN**

1. The PLAN shall assure suitable premises for Dental Centers within the Service Area.
2. The PLAN shall assure an adequate and suitable staff for the Dental Centers.
3. The PLAN shall arrange for the Participating Dentist to perform such other services as may be required to fulfill the intent and purposes of the Dental Service Agreement including, but not limited to, the administration, supervision, management and operation of the Dental Centers.
4. All professional services provided by the PLAN shall be performed so as to be in the best interest of the Plan Members, and shall, at all times, meet professional standards of quality.
5. The PLAN shall assure the availability of functioning Dental Centers for the Plan Members during the term of the Dental Service Agreement.
6. No Center Dentist shall use or prescribe any materials or drugs other than those approved by the United States Food and Drug Administration.
7. The PLAN shall supply to each Enrolled Member a Member Certificate listing covered procedures, limitations and exclusions.
8. The PLAN shall provide each member, upon request, a statement regarding providers' credentials and/or the financial arrangement between the PLAN and its providers.

**C. ELIGIBILITY**

As identified in Article I, an Eligible Member must:

1. Be a bona fide member, an active employee, a retiree or other member of a Group which has executed a Dental Services Agreement with the PLAN; and
2. Meet the Group's and the Member Certificate's eligibility requirements to participate in the PLAN.

In order for an Enrolled Member's Dependent to be a Plan Member, the Dependent must:

1. Meet the Group's and the Member Certificate's eligibility requirements for Dependent coverage; and
2. Be the legal spouse of an Enrolled Member; or
3. Be an unmarried child of an Enrolled Member, whether natural or adopted.

**D. ENROLLMENT**

Newly Eligible Members have a window period as defined by the Group to enroll themselves and eligible Dependents as Plan Members or must wait until the next Open Enrollment Period. Eligible Members with newly acquired Dependent(s) must enroll said Dependent(s) within thirty-one (31) days of the Dependent(s) becoming eligible or must wait until the next Open Enrollment Period.

Enrollment procedures vary by Group. Coverage becomes effective on the date agreed upon between the Group and the Plan.

**Article III**

**A. PREMIUM PAYMENTS**

Premium payments shall be paid to the PLAN in accordance with the terms of the Group Dental Service Agreement. The paid Premium amount identified in the Group Dental Agreement shall constitute full payment for the benefits to be provided under the Dental Services Agreement as listed on the Schedule of Benefits except for PLAN Member Co-payments.

**B. PLAN MEMBER PAYMENTS**

The PLAN may require a Plan Member to pay costs or charges for dental services performed by a Participating Dentist, which services are either identified as a Co-payment or not included on the Schedule of Benefits.

Examples include, but are not limited to, bonding, implants, full gold restorations and clear or ceramic braces.

**C. FAILURE TO REPORT TERMINATIONS**

Failure to report Plan Member terminations during the month in which they occur will result in the Plan Member being responsible for the full dollar amount of the service provided to the Plan Member and/or Dependent.

## Article IV

### Coordination of Benefits and Subrogation

- A. As used in this Article, the term “policy” or “certificate” shall mean a certificate, contract or policy issued by a health or medical care corporation, a hospital service corporation, a health maintenance organization, a dental care corporation, an insurance company, a labor-management trustee plan, a union welfare plan, an employer organization plan, or an insurance plan in connection with a group disability benefit plan under which health, dental hospital, medical, surgical, or sick care benefits are provided to a group of Enrolled Members.
- B. If the Plan Member has coverage under a policy or certificate which does not contain a coordination of benefits provision, the benefits under that policy or certificate will be determined prior to the PLANS Benefits.
- C. If the Plan Member has coverage under a policy or certificate which contains a coordination of benefits provision, the following rules apply:
  - 1. The benefits of a policy or certificate which covers the Plan Member on whose expenses the claim is based other than as a Dependent shall be determined before the benefits of a policy or certificate which covers the Plan Member as a Dependent.
  - 2. Except as otherwise provided in subdivision (3), if two policies or certificates cover a Plan Member on whose expenses the claim is based as a dependent, the benefits of the policy or certificate of the person whose birthday anniversary occurs earlier in the calendar year shall be determined before the benefits of the policy or certificate of the person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the benefits of a policy or certificate which covered the Plan Member on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or certificate which has covered the Plan Member for the shorter period of time. However, if either policy or certificate is lawfully issued in another state and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries as provided in this subdivision, and as a result each policy or certificate determines its benefits after the other, the

coordination of benefits procedure set forth in the policy or certificate which does not have the coordination of benefits based on birthday anniversaries shall determine the order of benefits.

3. In the case of a Plan Member for whom a claim is made as a Dependent child, benefits shall be determined according to the following:
  - a. Except as provided in subparagraph (c), if the parents of the child are legally separated or divorced, and the parent with custody of the child has not remarried, the benefits of a policy or certificate which covers the child as a dependent of the custodial parent shall be determined before the benefits of a policy or certificate which covers the child as a dependent of the noncustodial parent.
  - b. Except as provided in subparagraph (c), if the parents of the child are divorced, and the parent with custody of the child has remarried, the benefits of a policy or certificate which covers the child as a dependent of the custodial parent shall be determined before the benefits of a policy or certificate which covers the child as a dependent of the spouse of the custodial parent, and the benefits of a policy or certificate which covers the child as a dependent of the spouse of the custodial parent shall be determined before the benefits of a policy or certificate which covers the child as a dependent of the noncustodial parent.
  - c. If the parents of the child are divorced, and the decree of the divorce places financial responsibility for the medical, dental or other health care expenses of the child upon either the custodial or the noncustodial parent, the benefits of a policy or certificate which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any policy or certificate which cover the child as a dependent.
4. If subdivision 1, 2, or 3 do not establish an order of benefit determination, the benefits of a policy or certificate in connection with a group disability benefit plan which group disability benefit plan has covered the Plan Member on whose expenses the claim is based for the longer period of time shall be determined before the benefits of a policy or

certificate which has covered the Plan Member for the shorter period of time, subject to the following:

- a. The benefits of a policy or certificate covering the Plan Member on whose expenses the claim is based as a laid-off or retired employee or as a dependent of a laid-off or retired employee shall be determined after the benefits of any other policy or certificate covering the Plan Member other than as a laid-off or retired employee or a dependent of a laid-off or retired employee.
  - b. Subparagraph (a) shall not apply if either policy or certificate is lawfully issued in another state or does not have a provision regarding laid-off or retired employees and, as a result, each certificate determines its benefits after the other.
5. Benefits under the Group Dental Agreement will not be reduced or otherwise limited because of the existence of another non-group contract which is issued as a hospital indemnity, surgical indemnity, specified disease or other policy of disability insurance as defined in section 3400 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, being Section 500.3400 of the Michigan Compiled Laws.
6. The Plan is not required to pay claims or coordinate benefits for services which are not provided or authorized by the PLAN and which are not Benefits under the Dental Services Agreement. If it is determined that Benefits under the Group Dental Agreement should have been reduced because of benefits available under another policy or certificate, the Plan has the right to recover from the Plan Member any payments made to or assess a reasonable charge for rendered services in excess of PLAN's liability. Similarly, if Benefits due from the PLAN have been provided under another policy or certificate, the PLAN may directly reimburse the insurance company or other organization which provided the benefits. In order to coordinate benefits the PLAN may release, claim or obtain any necessary information from any insurance company or other organization. In addition, any Plan Member claiming benefits under the Group Dental Agreement shall furnish the PLAN with information as requested, necessary for administering this provision.

## B. SUBROGATION

1. Subrogation means that the PLAN will have the right as a Plan Member to recover expenses for services or supplies provided under the Dental Services Agreement for which another person or organization is legally liable. The PLAN will be subrogated to the Plan Member's right of recovery against the responsible person or organization.
2. The Plan Member shall fully cooperate with the PLAN in enforcing such subrogation rights as a condition to receiving benefits to services under the Dental Services Agreement. The Plan Member will make a good faith effort to pursue recovery from the liable party, and upon collection of any recoveries for any benefits and services provided by the PLAN will reimburse the PLAN. The PLAN will have a lien for any benefits and services rendered on any such recoveries whether by judgement, settlement, compromise or reimbursement.
3. Upon acceptance of receiving services or supplies under the PLAN the Plan Member is deemed to have granted the PLAN authorization to be subrogated to the Plan Member's right to bring suit. At the PLAN's expense and at the PLAN's request, the Plan Member shall execute a subrogation agreement affirming this authorization. If a suit brought by the PLAN on behalf of the Plan Member results in a monetary recovery in excess of the services and benefits provided by the PLAN, the PLAN shall have the right to recover its legal fees and costs out of the excess.
4. The Plan Member or his or her representative shall execute and deliver to the PLAN any instruments and papers and to whatever else is necessary to enable the PLAN to implement their right to subrogation. A Plan Member who engages legal representation to pursue a claim shall inform his or her counsel of the rights of the PLAN under the Dental Services Agreement. The Plan Member shall not compromise or settle a claim or take any action which would prejudice the rights and interests of the PLAN without the PLAN's prior consent.
5. Refusal or failure of the Plan Member, without good cause, to cooperate with the PLAN under this section shall be grounds for recovery by the PLAN from Plan Member for the value of the services and benefits provided by PLAN.

## Article V

### A. PATIENT RECORDS

Records shall be maintained by the Participating Dentist for each Plan Member to the extent and degree professionally required. As a part of such records there shall be maintained the date of each visit by each Plan Member, the diagnosis, the treatment, the name of the Participating Dentist performing such treatment, and any other vital and pertinent data deemed by the Participating Dentist to be necessary for the proper treatment and care of such patients. Any charges made to a Plan Member shall be recorded on such Plan Member's records. Records pertaining to a particular Plan Member shall be made available, when reasonably requested, for inspection by that Plan Member and those authorized, in writing, by such Plan Members to inspect such records. The PLAN shall, at the written request of the Plan Member or an authorized person acting on his behalf, supply a copy of the records, including radiographs and treatment plans, of such Plan Member to any doctor designated by the Plan Member. All records are the property of the Participating Dentist and copies shall be made available for inspection to the extent legally and professionally ethical.

### B. AVAILABILITY OF DENTAL RECORDS

Dental records (or copies thereof) required to be prepared and maintained pursuant to this Agreement shall be maintained and made available as herein required during the term of this Agreement and for a period of at least seven (7) years following the termination of this Agreement.

### C. CONFIDENTIALITY OF DENTAL CARE RECORDS

Information from dental records pertaining to Plan Members and information received from dental care providers relative to the dentist-patient relationship will be kept confidential. Except in connection with the administration of this Member Certificate, when required by law, for use in non-identifying data for statistical studies or in a bona fide dental research or education, information from dental records will not be disclosed without the consent of the Plan Member. The Plan Member agrees to cooperate with the PLAN by providing dental history information and by assisting in obtaining prior dental records as requested.

**D. ASSIGNMENT**

The Benefits provided under the Dental Services Agreement and/or the Member Certificate are for the personal benefit of the Plan Member and can not be transferred or assigned. Any attempt to assign the Dental Services Agreement and/or the Member Certificate will automatically terminate all rights. No payment will be made by the PLAN to any Dentist except under the Provisions of the Dental Services Agreement and/or the Member Certificate.

**E. CHANGE OF STATUS OR TRANSFER**

The Group or PLAN must receive notification within thirty-one (31) days after the occurrence of the event of a Plan Member's change in status resulting from such events as marriage, divorce, retirement, birth, death or any events affecting termination of coverage for Dependent children as defined in Article I.

The Plan must receive notification of any change of address or the address of any Enrolled family dependents. Failure to notify the PLAN of a change of address to outside the Service Area within a reasonable period of time may result in cancellation of the Plan Member's coverage under the PLAN.

**F. IDENTIFICATION CARD**

Because the Dental Centers are fully computerized with on-line eligibility capabilities, identification cards are unnecessary and therefore not issued to Plan Members.

**G. MEMBER SATISFACTION AND GRIEVANCE PROCEDURE**

The Plan considers patient satisfaction with the dental care they receive one of the most important aspects of our dental programs and the key to the success of your continued dental health. That is precisely why the PLAN has incorporated a formal Satisfaction and Grievance procedure(s) as an important component of the Dental Services Agreement.

For problems relating to dental care, the Dental Center visited should be notified first. Often the Office Manager or the Dental Director can resolve the problem promptly. If the Plan Member has discussed the problem with the appropriate personnel at the Dental Center in question and is still not satisfied with the resolution, the Plan Member should contact the PLAN Patient Service Representative (PSR).

The PSR can be contacted by calling the PLAN during regular business hours. The PSR will analyze and, as necessary, research the complaint and provide you with an answer to your inquiry as quickly as possible. If you do not choose to call, you may write to the PLAN at the following address: **Midwestern Dental Plans, Inc., 5050 Schaefer Road, Dearborn, Michigan 48126.** Patient Service Phone: 1-800-544-6374, Fax: 313-581-6827.

If the Plan Member's inquiry cannot be answered immediately the PSR will fully investigate the complaint and respond to the Plan Member within twelve (12) calendar days of receipt. If the complaint is not resolved to the Plan Member's satisfaction, the Plan Member has the right to grieve through a formalized appeals process outlined in the PLAN'S Grievance Procedure. Receipt of a request commences the Grievance Process and is subject to a thirty-five day (35) time frame. The time frame may be tolled for any period of time the insured or enrollees is permitted to take under the procedure and for a period that shall not exceed ten business days if the PLAN has not received information from health care facility or health professional.

### **Midwestern Dental Plans, Inc. Grievance Procedure**

#### **STEP ONE**

If you wish to appeal the denial of a claim for reimbursement or request a review regarding a dental care issue you may do so in writing within two years of receiving an adverse determination by contacting: **Midwestern Dental Plans, Inc., 5050 Schaefer Road, Dearborn, Michigan 48126, Attention: Patient Service Manager: Phone 1-800-544-6374, Fax: 313-581-6827.** The Patient Service Manager will fully investigate the grievance and will respond in writing within five calendar days of receipt of said appeal. Any new findings or decisions and/or documentations will be reviewed as part of the process. If the Patient Service Manager's actions satisfy the Plan Member, the appeal is resolved.

#### **STEP TWO**

Should the Plan Member wish to proceed further with the grievance, the Plan Member may appeal the decision in writing within sixty (60) days to the Patient Services Manager (at the address listed in Step One) for a review by the Grievance Committee. The review will take place no later than seven (7) calendar days from receipt of the written request. The decision of the Grievance

Committee will be communicated to the Plan Member in writing within two (2) calendar days following the meeting.

### **STEP THREE**

If the Plan Member is dissatisfied following Step Two, he/she may submit yet another written appeal to the Patient Services Manager within sixty (60) days of receiving the Grievance Committee's decisions. The appeal will be reviewed by the Executive Committee of the Board of Directors at their next meeting which will take place no later than seven (7) calendar days from receipt of the written appeal. At that time, the Plan Member, or his/her delegated representative, or both has the option to personally present his/her case to the Board. The Board will forward a written communication to the Plan Member of its' decision and the reasons for an adverse determination, within two (2) days of the meeting. Upon the adverse determination the Plan Member has the right to an external review process administered by the Division of Insurance. Forms to request the external review are included with each adverse determination or can be obtained through the website address listed in Step Four. A request for an external review with the Commissioner shall not be made until the Member has exhausted the Plan's internal grievance process provided by law.

### **STEP FOUR**

Under Public Act 251 of 2000, known as the Patients Right to Independent Review Act (PIRA), the Plan Member, upon receipt of an adverse determination, has the right to an external review process administered by the Division of Insurance. The Plan Member may file for an external review with the Commissioner not later than sixty days after receipt of an adverse determination by the Plan. The new address to send the appeal to is Office of Financial & Insurance Division, Division of Insurance, Health Plan, 611 West Ottawa, Second Floor, P. O. Box 30220, Lansing Mi. 48909-7720: Phone 517-335-2057. A publication is available outlining this process by contacting toll free 877-999-6442. The forms required to request an external review will be included with our final adverse determination and is also available at the following website: [www.cis.state.mi.us/ofis](http://www.cis.state.mi.us/ofis). The Plan Member may request for an expedited review with the Commissioner no later than ten days after receipt of an adverse determination.

## **EXPEDITED GRIEVANCE PROCEDURE**

The same process will be used by expedited reviews, however the time lines are reduced to seventy two hours. The Plan Member may request an expedited review with Midwestern Dental Plans if the Plan Member's physician, orally or in writing substantiates that the time frame for a grievance would acutely jeopardize the life of the Plan Member, the Plan will expedite the grievance process by making an initial determination no later than seventy two hours after receipt of the grievance. If the determination is made orally, the Plan will provide the Plan Member with written confirmation within two business days. Submit the expedited external review contact persons listed below. The Plan Member may request for an expedited external review no later than ten (10) days after receipt of a Midwestern Dental Plans adverse determination. Expedited Review Contact List. 1.) Julie Dennis, Patient Advocate Phone: 1-800-544-6374, Fax: 1-313-581-6827, E-mail jdennis.mdpi@netzero.net 2.) Maris Goshorn, Patient Service Manager, Phone: 1-800-544-6374, Fax: 1-313-581-6827, E-mail mgoshorn.mdpi@netzero.net.

## **EXTERNAL COMPLAINT PROCESS DIVISION OF INSURANCE**

The Division of Insurance receives the written complaint/inquiry. The staff reviews for health care service or non-health care related matters. Non-health care service related matters are handled through the Division of Insurance's existing complaint process. Health care related service matters meeting the definition of an adverse determination could potentially go to an external review and is put through a separate process with distinct time frames and requirements.

### **STEP ONE:**

Upon receipt of the Plan Member's request for an external review, the Division of Insurance will conduct the preliminary review per specific criteria set forth in Section 11 (2) P.A. 251 of 2000. This review must be completed within five (5) days. When the preliminary review is completed one of the following steps will occur.

1. If the staff determines the request does not meet the criteria for an external review, a letter of explanation will be sent to the Plan Member as to why the request was not approved.
2. If the staff determines the request does meet the criteria for external review the following will occur.

### **Medical Issues**

The Division of Insurance will assign an Independent Review Organization (IRO). The staff will prepare notification letters to the Plan Member and the Plan. The IRO has fourteen (14) calendar days to review and respond to the Division of Insurance with their recommendation. During this period, the Plan Member or the Plan has seven (7) business days after receipt of notification to provide additional documentation to the IRO. After the receipt of the IRO recommendation, the Commissioner will review the recommendation. Communication to the Plan Member and the Plan must be made within seven (7) business days after the receipt of the IRO recommendations regarding the Commissioner's decision to uphold or reverse the adverse determination.

### **Non-Medical Contractual Issues**

The Division of Insurance will respond to the Plan Member and the Plan informing them that the external review will be conducted by the Division of Insurance staff. The staff will have fourteen (14) calendar days to review the staff recommendations. Communications to the Plan Member and Plan must be made within seven (7) business days after the review of the staff recommendations regarding the Commissioner's decision to uphold or reverse the adverse determination.

The response to the Plan Member and the Plan will include the principal reason or reasons for the decision, including, as an attachment to the notice or in any other manner the Commissioner considers appropriate, the information selected by the IRO. If appropriate, the principal reason or reasons why the Commissioner did not follow the IRO recommendation.

### **Request for Expedited Review**

The Plan Member may request a expedited review with the Commissioner no later than ten (10) days after receipt of an adverse determination. The same process will be used for expedited reviews, however, the time lines are reduced to seventy two (72) hours. The Division of Insurance staff will utilize the Plan's designee for expedited communication in these cases.

### **Division of Insurance Requirements**

The Insurance Bureau requires a summary data on the number of complaints and grievances. The Plan will file data on supplied forms by the Insurance Commissioner on an annual basis with the Commissioner. A review committee, comprised of administrative and health care professionals meet on a semi-annual basis to review data on complaints and grievances to assure appropriate actions were taken.

The Plan maintains copies of all complaints and grievances at the principle office. Those are available for inspection by the Insurance Bureau for period of two years.

\*Member has 2 years from date of discovery of a problem to file a grievance.

#### H. IDEMNIFICATION

The PLAN shall idemnify and hold the Group harmless from and against any and all liabilities, losses, damages, expenses, claims and costs to which the Group might hereafter be subjected as a result of any act or omission on the part of the PLAN, an employee of the PLAN, or Participating Dentist.

## Article VI

### Termination of Coverage

The Member Certificate shall continue in effect for one year from the effective date and renewable annually thereafter, subject to reasonable notice and grievance rights as follow:

1. Failure of payment of the Premium to the PLAN within thirty (30) days after said premium is due, at option of the PLAN; or
2. Termination of eligibility of the Plan Member as a member of the Group or failure to meet eligibility requirements as contained in Article I. However, upon request by the Plan Member and verification by the PLAN that the Plan Member is eligible, the Plan Member may continue treatment pursuant to the Plan Member's rights as indicated pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986, Title X (COBRA).

Additional reasons for termination include:

- a. Providing false or misleading information.
- b. If Plan Member has repeatedly acted in a manner abusive or obstructive to staff or other patients or has repeatedly and intentionally misused or fraudulently accessed the PLAN.
- c. If after reasonable efforts the Participating Dentists are unable to establish a satisfactory dentist-patient relationship with a Plan Member, that Plan Member may be asked to disenroll or the Plan Member and the entire family enrolled as a family unit may be terminated by the PLAN not less than 30 days after written notice. In the event of termination coverage will cease at the end of the payment period in which failure to pay occurred or at the time termination of eligibility occurred with the Group.

## Article VII

### Exceptions, Exclusions and Other Limitations

- A. The term "Covered Dental Services" as used herein shall exclude the following:
1. Services for which Benefits are otherwise provided under a surgical-medical plan of the Group.
  2. Services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures.
  3. Prosthetic devices (including bridges, crowns, inlays, onlays and complete partial dentures and the fitting thereof) for which the final impressions were taken while the individual was not covered under this Agreement, or for which final impressions were taken while the individual was covered under this Agreement, but are not finally installed or delivered to such individual within sixty (60) days after the termination of coverage.
  4. Replacement or repair of an orthodontic appliance.
  5. Services which are compensated by Workers' Compensation or Employer's Liability.
  6. Dental services which are obtained by a Plan Member outside of the Dental Center in which he is enrolled and which are not pre-authorized by the PLAN. This exclusion does not apply to Out-Of-Area Emergency dental services as defined in Article I.
  7. Services or supplies from any governmental agency which are obtained by the Plan Member without cost in compliance with laws or regulations enacted by any federal, state, municipal, or other governmental body.
  8. Services to the extent for which benefits are payable under any health care program supported in whole or in part by funds of the federal government or any state or political subdivision thereof.
  9. Services for treatment of any automobile-related injury to the extent to which the Plan Member is covered under any no-fault automobile policy.
  10. Services rendered through any facility provided or maintained by the Plan Member's employer such as a medical department or clinic.
  11. Services or supplies received for treatment of any dental disease, defect, accident or injury

due to an act of war, declared or undeclared or participation or involvement in a riot or act of civil insurrection or during the commission of a felony.

12. Elective dentistry or oral surgery.
13. Services or supplies which do not meet accepted standards of dental practice, including services and supplies which are experimental in nature.
14. Treatment of fractures, dislocations, malignancies and neoplasms.
15. Treatment of myofacial pain syndrome, temporomandibular joint (TMJ), or temporomandibular dysfunction (TMD) is excluded.
16. Treatment to alter vertical dimension (except when involving full dentures and/or minor occlusal adjustments or orthodontic therapy).
17. Expenses for occlusal equilibration except to the extent necessary to treat periodontal disease.
18. Treatment of major congenital defects, such as cleft palates, congenitally missing teeth and associated deformities.
19. Implantology, (i.e., implants driven into or resting on a alveolar bone, used to support a crown, a full denture, or to act as an abutment for a fixed bridge when no abutment tooth is available or the surgical procedures on the jaws in preparation for the prosthesis). Both the surgical procedure and the prosthetic appliance are excluded.
20. Any duplicate prosthetic device or any other duplicate appliance.
21. Orthodontic treatment for a Plan Member subsequent to such person attaining the age of nineteen (19) unless said Plan Member is banded prior to his nineteenth (19) birthday or unless it is stated otherwise in the Schedule of Benefits. It is to be understood that said Plan Member remains eligible until the completion of Orthodontic treatment. Should eligibility be terminated, the Plan Member will be responsible for any unpaid balance.
22. Repair of full or partial dentures, except within six (6) months of delivery, after which the applicable Co-payment will apply as identified in the Schedule of Benefits.
23. Replacement of an existing removable partial or full removable denture or fixed bridgework by a new denture or by new bridgework, or the addition of teeth to an existing removable partial or to bridgework, unless:

- A. Satisfactory evidence is presented that the replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed.
  - B. The existing denture or bridgework cannot be made serviceable and at least five (5) years have elapsed.
  - C. The existing denture is a temporary denture which cannot be made permanent. The replacement by a permanent denture must take place within twelve (12) months on insertion of the immediate temporary denture
- 24. All replacement of teeth where bilaterally edentulous (where teeth are missing on both sides of the same arch) areas exist are to be performed with removable prosthesis as compared to a fixed prosthesis.
  - 25. Retreatment of a completed orthodontic case. Orthodontic treatment is a once in a lifetime benefit.
  - 26. Completion of orthodontic treatment for a patient who presents having had prior orthodontic treatment of an inappropriate nature.
  - 27. Sealants are not a covered benefit except as stated otherwise in the Group Schedule of Benefits.
  - 28. Prosthetic services such as precision attachments, copings, over-dentures and stress breakers.
  - 29. Gold teeth in removable prosthesis as well as clear palates in a complete upper denture.
  - 30. Prescription drugs, laboratory tests and/or examinations, pre-medications and charges for hospitalization.
  - 31. Orthognathic Surgery
  - 32. No coverage is provided due to the effects of abrasion, attrition or erosion, or as the result of injurious oral habits.
  - 33. Services which were stated prior to the individual enrolling in the Plan, e.g. root canals, crown and bridge, etc.
  - 34. Treatment of unmanageable children or otherwise unruly patients. An attempt will be made to treat all patients. However, if a patient is untreatable by virtue of apprehension or for any other reason, and is referred to another office for treatment, the responsibility for payment lies with either the patient or with the guardian of the patient.

35. Services arising from any intentionally self-inflicted injury or contusion.
36. Services that can not be performed in the dental facility due to the general medical, mental or physical limitations of the Plan Member. The Plan Member is responsible for any cost incurred.
37. Services which are necessitated by lack of patient cooperation or failure to follow a professionally prescribed treatment plan.
38. Additional covered services, other than a dental emergency, if the Member has previously unresolved copayment balance that has been outstanding for sixty (60) or more days, unless special payment arrangements have been made within the primary care dentist or dental specialist.
39. Full mouth reconstruction.
40. Repairs to an old prosthesis that has been replaced with a new prosthesis.
41. Continuation of orthodontic treatment where there has been greater than a six month lapse in treatment.

B. Limitations are defined as:

1. Full mouth or panoramic radiographs once every three years.
2. Prophylaxes are covered twice in any contract year except as stated otherwise in the Group Schedule of Benefits.
3. Fluoride is covered up to the age of nineteen (19).
4. Single crowns, bridge abutments and pontics are covered for non-precious metals only.
5. Root canal therapy is covered for traditional fill materials (gutta percha and silver points) and not Sargenti type materials.
6. Repairs to an old prosthesis that has been replaced with a new prosthesis are not a covered benefit.
7. Relines on traditional dentures are covered beginning six (6) months after delivery then once every three years after that. Relines on immediate dentures can be done anytime after delivery (no six month wait necessary) and then once every three years. There is no differentiation between lab and office relines or soft versus hard relines with regard to the same limitations.
8. All adjustments to complete or partial dentures are covered for six months after delivery. After that time, a separate charge will

be made for adjustments to either the upper or lower prosthesis or both in accordance with the Schedule of Benefits.

9. Repairs, replacement or retreatments of restorations or endodontics are performed at no charge for twenty-four (24) months. After that time the applicable Co-payment will apply as identified in the Schedule of Benefits.
10. If any of the procedures performed in Oral Surgery and Periodontics are covered under any medical benefit plan(s), then exception A.1. would apply.
11. Orthodontics, for those Groups providing an orthodontic Benefit, is covered until the age of 19 unless stated otherwise in the Group Schedule of Benefits.
12. Optional Treatment: In all cases in which the Plan Member selects a more expensive service or benefit than is customarily provided or for which the PLAN does not believe a valid dental need is shown, the PLAN will allow for the applicable percentage of the fee for the service or benefit, if any, which is customarily provided to restore the tooth to contour and function. Fee of the lesser service or benefit to be applied towards the elected procedure. The Plan Member will pay the difference.

EXAMPLE:

A tooth can be satisfactorily restored with amalgam. The Plan Member, however, chooses to have the tooth restored with a more costly material. The PLAN will only provide for the applicable amount that it would have allowed to restore the tooth with amalgam. The Plan Member is responsible for the difference in cost.

13. Authorized or Covered Dental Services incurred as a result of an emergency as defined in Article I shall be covered limited to a maximum reimbursement of fifty dollars (\$50.00) (for the relief of pain and suffering) of the Plan's usual and customary and reasonable fee.

Out-of-Area Emergency Procedures:

In the event a Plan Member experiences a dental emergency while out of the area, the individual should seek professional care to alleviate pain and suffering. A determination for reimbursement will be made and communicated to the Plan Member within

five days of said claim. The claim for the services provided should be submitted to:

Midwestern Dental Plans, Inc.  
5050 Schaefer Road  
Dearborn, MI 48126

Attention: Patient Services Representative

14. Dental Services for individuals requiring additional or unusual efforts to complete a dental procedure, e.g. denture requiring obturation, microscopic procedures associated with root canals, surgical correction of dento-facial deformities, etc.
15. Retreatment of previously treated root canals while a member is limited to a three year period.
16. Retreatment of root canals completed prior to enrolling in the Plan will be subject to the Plan's usual, customary and reasonable fees for the retreatment of root canals. (Codes for retreatment are: Anterior: 3346, Bicuspid: 3347, Molar: 3348).

#### LIMITATIONS:

The following services will be subject to the limitations as set forth below:

- A. One (1) in a six month period:
  1. Periodic oral exam
  2. Routine prophylaxis
  3. Fluoride Treatment
  4. Bitewing x-rays for dependents through the age of twelve (12) maximum four (4) per occurrence.
- B. One (1) in a twelve (12) month period:
  1. Bitewing x-rays for dependents through the age of thirteen (13) and over, maximum four (4) per occurrence.
- C. One (1) in a twenty four (24) month period:
  1. Scaling and root planning
  2. Mucogingival surgery
  3. Osseous surgery
  4. Gingival flap per quad
  5. Gingivectomy per quad
  6. Gingivectomy per tooth
- D. One (1) in a three (3) year period:
  1. Full mouth series and panoramic x-rays.
- E. One (1) in a five (5) year period (if found to be unserviceable):
  1. Complete dentures

2. Partial dentures
  3. Fixed bridges
- F. One (1) per tooth per lifetime:
1. Prefabricated stainless steel crowns - primary or permanent teeth
  2. Crown lengthening
- G. The following series are specifically limited to:
1. Space maintainers-  
<for Dependent children through the age of eighteen (18) when used to maintain space as a result of prematurely lost deciduous teeth and permanent first molars or deciduous teeth and permanent molars have not, or will not ever develop, (See Schedule of Benefits).
  2. Sealants-  
<for children through age fourteen (14) on a per tooth basis (See Schedule of Benefits).  
<not eligible within three (3) years of placement unless provided by other than the original dental facility.
- H. Orthodontics is a once in a lifetime benefit. If Orthodontic treatment has been completed elsewhere there is no further benefit available under the Member's Plan. Members presently in orthodontic treatment at the time of enrolling in the Plan are eligible for treatment minus time already served in treatment.

**MIDWESTERN DENTAL PLANS, INC.  
MDPI  
PRIVACY STATEMENT**

We at Midwestern Dental Plans, Inc. (MDPI) realize that our customer's privacy is of paramount importance. That is why we want our customers to understand that we do not sell or disclose any personal information about our customer without consent unless we are permitted to do so by law. This holds for current and former customers.

In order to serve our customers MDPI must collect, use and disclose certain information about them. This information comes from various sources. The information may be provided by the customer, such as on an application form. It may come in the form of enrollment lists from the employers. It may come from transactions with our affiliates or third parties. Information may also come from state or federal agencies.

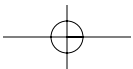
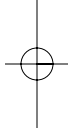
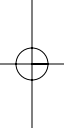
The type of information collected may include, by example: health histories, dental services rendered, account balances and payment history.

MDPI will only disclose information about our customers as provided by law. We may disclose personal information to affiliated companies or third parties to deal with complaints and grievances about a customer's care or to provide information required by government or accreditation agencies. We do not share identifiable health information unless the customer or the applicable law authorizes such sharing.

MDPI restricts access to personal information to those employees, agent representatives or third parties who have a direct need and a legal right to see that information. We maintain safeguards through various policies and procedures to protect our customer's personal information. We regularly review these safeguards to make sure our customer's privacy is protected.

MDPI reserves the right to change or modify privacy policies and related procedures at anytime, in accordance with applicable state and federal law. Our customers will receive notice if these changes do occur.

Additional information regarding these privacy policies may be obtained by contacting our Member Services Representative at 1-800-544-6374, or on the Internet at [www.midwesterndental.com](http://www.midwesterndental.com).





## **Midwestern Dental Plans**

*Building solid foundations  
for good dental health*

5050 Schaefer Road  
Dearborn, Michigan 48126

(313) 581-6824

1-800-544-MDPI

*A for-profit Michigan corporation.*



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