CHORUS
COMMUNITY HEALTH PLANS

Dental Evidence of Coverage – 2023

Chorus Community Health Plans, Inc. (CCHP)
[PO Box 1997, MS6280
Milwaukee, WI 53201
1-877-389-9870]

Underwritten by Chorus Community Health Plans, Inc.

Stand Alone Dental Plan – Evidence of Coverage

Preferred Provider Organization

Welcome to Chorus Community Health Plans! *We* are happy you've chosen *Us* to be *Your* dental insurance partner. This *Contract* contains the terms and conditions of *Your* insurance coverage. *We* issued this *Contract* in consideration of *Your* application and payment of the first premium.

IMPORTANT NOTICE: STATEMENTS MADE IN *YOUR* APPLICATION

Please write *Us* within 10 days if any information submitted in *Your* application is incorrect or incomplete. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. The insurance coverage was issued on the basis that the answers to all questions and other information shown on the application were correct and complete.

RIGHT TO RETURN

You have the right to return this *Contract* within 10 days of receipt. All premiums paid will be refunded, less claims paid, and the *Contract* will be considered null and void from the *Effective Date*.

GUARANTEED RENEWABILITY

This *Contract* remains in effect and is guaranteed renewable each year except under conditions identified in the 'Enrollment' and 'Termination' sections of this *Contract*. *You* must be eligible for insurance and pay *Your* premium to remain insured. Please read *Your Contract* carefully and become familiar with its terms, limits, and conditions.

IMPORTANT NOTICE: CHANGES TO THE *CONTRACT*

If the terms and conditions of this *Contract* change, *We* will attach legal documents called Riders and/or Amendments. *We* will notify *You* in writing of any changes to this *Contract*. No one can make any changes to the *Contract* unless those changes are in writing.

We have the right to change, interpret, modify, withdraw, add benefits, or to terminate the *Contract* as permitted by law, without *Your* approval. On its *Effective Date*, this *Contract* replaces and overrules any *Contract We* may have previously issued to *You*. This policy will take effect on the *Effective Date* specified in the 'Enrollment and Coverage Provisions' section of this *Contract*. Coverage under this *Contract* will begin at 12:00 a.m. CST and end at 11:59pm CST. The *Contract* is issued in the state of Wisconsin and is governed by applicable state and federal laws.

IMPORTANT NOTICE: SERVICES OBTAINED FROM *OUT-OF-NETWORK PROVIDERS*

CCHP has contracted with specific *Dental Providers* who have agreed to accept a contracted rate for Covered Services they perform. When *You* visit an in-network *Dental Provider*, the discount will lower *Your* out-of-pocket costs. If *You* choose to access an out of network *Dental Provider*, benefits will be determined based on the out-of-network benefit level. CCHP will pay its *Maximum Allowed Amount* of the covered charges, and *You* will be responsible for the remaining balance.

TABLE OF CONTENTS

INTRODUCTION

Welcome to Chorus Community Health Plans. *We* are pleased to provide *You* with this *Contract*. This *Contract* will explain *Your Benefits*, rights and responsibilities, and other important information about *Your* dental insurance coverage. *We* encourage *You* to read this *Contract* carefully and store it in a place *You* can find it quickly. Many of the sections of this *Contract* are related to other sections of the document, so *You* may not have all the information *You* need by reading just one section. Please call Customer Service at [1-877-389-9870] if *You* have any questions. Representatives are available from 8 a.m. – 5 p.m. Monday – Friday, as well as available to triage emergency care on the weekends and holidays.

DEFINED TERMS

We have included a Terms and Definitions section to help explain certain terms. If a word is *Capitalized* and *Italicized* in the document, it will be included in the Terms and Definitions section. When *We* use the words *We*, *Us,* and *Our, We* are referring to Chorus Community Health Plans or CCHP. When *We* use the words *You* and *Your*, *We* are referring to those who are *Covered Persons.*

***YOUR* CIVIL RIGHTS**

CCHP complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, disability, or other legally protected status, in its administration of the plan, including enrollment and benefit determinations.

CCHP provides appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and individuals who have language service needs, and information in alternate formats, free of charge and in a timely manner, when such aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age, or disability may file a grievance in person, by mail, fax, or email. The grievance must be filed within 180 days of the person filing the grievance becomes aware of the alleged discriminatory action. It is against the law for CCHP to retaliate against anyone who files a grievance, or participates in the investigation of a grievance. Members can request CCHP's grievance procedure by contacting the Section 1557 Coordinator:

Director, Corporate Compliance	Telephone: (414) 266-2215
[Mail Station C760	TDD-TTY (for the hearing impaired): (414) 266-2465
P.O. Box 1997	Fax: (414) 266-2215)
Milwaukee, WI 53201-1997	ttwinem@childrenswi.org]

Members must submit their complaints in writing with their name, address, the problem or action alleged to be discriminatory, and the remedy or relief sought. Members can also file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: [https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf], or by mail at:

U.S. Department of Health and Human Services
[200 Independence Avenue
SW Room 509F HHH Building
Washington, D.C. 20201]

Complaint forms are available at [https://www.hhs.gov/civil-rights/filing-a-complaint/complaint process/index.html]

LANGUAGE SERVICES:
If *You* or someone *You're* helping has questions about CCHP, *You* have the right to get help and information in *Your* language at no cost. To talk to an interpreter, call [1-800-264-1552]. If *You* are hearing impaired, call the Wisconsin Relay at 7-1-1.

***YOU* HAVE THE RIGHT TO:**

- Ask for an interpreter and have one provided to *You* during any *Covered Service*.
- Receive the information provided in another language or another format.
- Receive dental services as provided for by Federal and State law. All *Covered Services* must be available and accessible to *You*.
- Receive information about treatment options including the right to request a second opinion regardless of the cost or benefit coverage.
- Participate with *Dental Providers* in making decisions about *Your* dental care regardless of the cost or benefit coverage.
- Be treated with dignity and respect.
- *You* have a right to privacy regarding *Your* health.
- Be free from any form of restraint or seclusion used as a means of force, control, ease, or reprisal.
- Receive information about *Us*, *Our* services, and *Dental Providers* and member rights and responsibilities.
- Voice complaints or appeals with *Us* or the care *We* provide.
- Make recommendations regarding O*ur* member rights and responsibilities policy.
- A candid discussion of appropriate or *Medically Necessary* treatment options for *Your* condition, regardless of cost or benefit coverage.

***YOU* HAVE THE RESPONSIBILITY TO:**

- **Read this *Contract***
  Read and understand to the best of *Your* ability all materials concerning *Your* dental *Benefits* and ask for help if *You* need it by calling Customer Service at [1-877-389-9870].

- **Be enrolled and pay required contributions and premiums**
  Benefits are available to *You* only if *You* are enrolled for coverage under this *Contract*. *Your* enrollment options, and the corresponding dates that coverage begins are listed in the 'Enrollment Provisions' section of this *Contract*.

- **Be Aware this *Contract* does not pay for all dental services**
  Your right to *Benefits* is limited to those services that are defined as *Covered Services*. The extent of this *Contract's* payments for those *Covered Services* and any obligation that *You* may have to pay for a portion of the cost of these *Covered Services* is set forth in the Schedule of Benefits. Just because *Your Dental Provider* recommends a service, does not guarantee that it is a *Covered Service*. Please consult the Schedule of Benefits or call Customer Service to confirm that any services that are to be rendered are *Covered Services.*

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

- **Participate in *Your* own Dental Care**
  Decisions are between *You* and *Your Dental Provider*. Talk to them about what they need to know to treat *You* and help to the extent possible by supplying information that *Dental Provider* needs to provide care. Follow the treatment plan agreed upon by *You* and *Your Dental Provider*. *You* have the responsibility to understand *Your* health problems and participate in developing mutually agreed upon treatment goals, to the extent possible. *Your Dental Provider* and their team may use clinical guidelines based on medical necessity to make decisions and recommendations about *Your* dental treatment and care. Those guidelines follow the general standard of care and are based on the American Dental Association guidelines which are available to *You* upon request.

- **Pay *Your* Share**
  You must pay an annual *Deductible* and/or *Coinsurance* for most *Covered Services*. These payments are due at the time of service or when billed by the *Dental Provider. Deductible* and *Coinsurance* amounts are listed in the Schedule of Benefits. *You* may also be required to pay the difference between the actual charge and the *Maximum Allowed Amount* plus any *Deductible* and/or *Coinsurance*.

- **Pay the Cost of Excluded Services**
  You must pay the cost of all excluded services and items. Review the 'Coverage Exclusions' section to become familiar with *Our* exclusions.

- **Show *Your* Identification Card**
  You should show *Your* identification card (ID) every time *You* request dental services. If *You* do not show *Your* ID card, the *Dental Provider* may fail to bill the correct amount for the services delivered, and any resulting delay may mean that *You* will be unable to receive *Benefits*.

NOTICE OF PRIVACY PRACTICES

This notice describes how *Protected Health Information* about *Our Covered Persons* may be used and disclosed and how *You* can get access to this *Protected Health Information*. Please review this notice carefully.

We are committed to protecting *Your* personal privacy. This notice explains *Our* Privacy Practices, legal responsibilities, and *Your* rights concerning *Your Protected Health Information*.

We reserve the right to change O*ur* privacy practices and the contents of this Notice of Privacy Practices as allowed by law. When *We* make a significant change in *Our* privacy practices, *We* will change this notice and send this notice to *Our Covered Persons* or post it on *Our* website at [chorushealthplans.org].

PRIVACY OBLIGATIONS

We are required by law to:

- Ensure that *Protected Health Information* is kept private.
- Provide to *You* a Notice of Privacy Practices.
- Follow the terms of this Notice of Privacy Practices.
    - *We* may use and disclose *Your Protected Health Information*:
        - To *You*, someone who is involved in *Your* patient care, or to a close friend or family member about *Your* condition, *Your* admission to a health care facility, or death.
        - To the Secretary of the Department of Health and Human Services.
        - To public health agencies in the event of a serious health or safety threat.
        - To authorities regarding abuse, neglect, or domestic violence.
        In response to a court order, search warrant, or subpoena.
        - For law enforcement purposes.
        - For research purposes if the research study meets all privacy law requirements.
        - For specialized government functions such as the military, national security, and intelligence activities.
        - To a coroner, medical examiner, or funeral director.
        - For the procurement, banking, or transplantation of organs, eyes, or tissue.
        - To comply with worker's compensation or similar laws.
        - To health oversight agencies for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and programs.

    - *We* have the right to use and disclose *Your Protected Health Information* to pay for health care services and operate *Our* business:
        - To a doctor, a facility, or other health care provider, which asks for *Your Protected Health Information* in order for *You* to receive health care.
        - To pay claims for *Covered Services* provided to *You* by doctors, facilities or other health care providers.
        - For the operations of CCHP such as processing *Your* enrollment, responding to *Your* inquiries, addressing *Your* requests for services, coordinating *Your* care, resolving disputes and activities for conducting medical management, quality assurance, auditing and evaluation of health care professionals.
        - To contact *You* with information about health-related benefits and services or treatment alternatives that may be of interest to *You*.

Certain services may be provided to CCHP by other organizations known as "business associates." For example, a third-party administrator may process *Your* claim so the claim can be paid. *Your Protected Health Information* will be provided to the business associate so the claim can be paid. All business associates will be required by *Us* to sign an agreement to safeguard *Your Protected Health Information*.

All other uses or disclosures of *Your Protected Health Information* require *Your* written authorization before the *Protected Health Information* is used or disclosed. *You* may revoke *Your* permission at any time by notifying *Us* in writing. Any *Protected Health Information* previously used or disclosed based on *Prior Authorization* cannot be revoked or reversed.

***YOUR* RIGHTS**

The following are *Your* rights with respect to *Your Protected Health Information*:

- **Inspect and copy**. *You* have the right to inspect and receive a copy of *Your Protected Health Information*. To perform an inspection or request a copy, *You* must submit a request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. *You* may be charged a reasonable fee for copies provided. In limited circumstances *You* may be denied the opportunity to inspect and copy *Your Protected Health Information*. Generally, if *You* are denied access to *Your Protected Health Information*, *You* may request a review of the denial.

- **Request amendment**. *You* have the right to request an opportunity to amend any *Protected Health Information* that *You* feel is incorrect or incomplete. To request the opportunity to amend *Your Protected Health Information*, *You* must send a request to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. This request must contain the reason *You* feel the *Protected Health Information* is incorrect or incomplete. *Your* request to amend *Your Protected Health Information* may be denied such as where the *Protected Health Information* is:
    - Accurate and complete.
    - Not created by *Us*.
    - Not included in the *Protected Health Information* kept by or for CCHP.
    - Not *Protected Health Information You* have the right to inspect.

- **Request an accounting of disclosures.** *You* have the right to obtain from CCHP a list of disclosures the plan has made to others, except those disclosures necessary for treatment, payment, health care operations or disclosures made to Y*ou* or other certain types of disclosures. To request an accounting of disclosures, *You* must submit *Your* request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. *Your* request must state a time period, which may not be longer than six years before the date of the request. If *You* request a list of disclosures more than once in a 12-month period, *We* may charge *You* a reasonable, cost–based fee for responding to these requests.

- **Request restrictions.** *You* have the right to request a restriction on the *Protected Health Information* disclosed about *You* for treatment, payment, or health care operations. CCHP is not required to agree to *Your* request. To request restrictions, *You* must submit *Your* request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. *You* must include in *Your* request:

    - The information *You* wish to restrict.
    - Whether *You* wish to limit the use or disclosure of the *Protected Health Information*, or both.
    - To whom *You* want the restriction to apply.

- **Request confidential communications.** *You* have the right to request that CCHP communicates with *You* about health matters in a certain way or in a certain location. To request confidential communications, *You* must submit *Your* request in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices. *Your* request must indicate how and/or where *You* wish the confidential communication to occur. *We* will make every attempt to accommodate all reasonable requests for confidential communications.

- **Paper copy of the Notice of Privacy Practices**. *Covered Persons* may request a copy of this notice at any time. *You* may submit *Your* request for a copy of this notice in writing to the Plan Administrator at the address listed at the end of this Notice of Privacy Practices.

- **File a written Complaint.** If *You* believe *Your* privacy rights under this *Contract* have been violated, *You* may file a written complaint with CCHP's Privacy Officer at the address listed below. Alternatively, *You* may complain to the Secretary of the United States Department of Health and Human Services. *You* will not be penalized or incur retaliation for filing a complaint.

- **Plan Administration and Privacy Officer contact information:**

Plan Administrator

Chief Operating Officer
Chorus Community Health Plans
[PO Box 1997
Milwaukee, WI 53201
1-414-266-6328]

Privacy Officer

Director of Corporate Compliance
Chorus Community Health Plans
[PO Box 1997
Milwaukee, WI 53201
1-414-266-2215]

TERMS AND DEFINITIONS

ADVERSE BENEFIT DETERMINATION
A denial, reduction, termination of, or failure to provide or make payment, in whole or in part, for a *Benefit*, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a *Covered Person's* eligibility to participate in a plan. *Adverse Benefit Determination* also includes a rescission of coverage.

ANNUAL BENEFIT MAXIMUM
The maximum dollar amount *We* will pay for *Your* dental care per calendar year. To determine what *Your Annual Benefit Maximum* is, please reference *Your Schedule of Benefits*. After the *Annual Maximum Benefit* has been met, the provider may bill *You* the remainder of the fees they charge.

AUTHORIZED REPRESENTATIVE
An individual who represents *You* in an internal appeal or external review process of an *Adverse Benefit Determination* who is any of the following:

- A person to whom a covered individual has given express written consent to represent that individual in an internal appeals process or external review process of an *Adverse Benefit Determination*;
- A person authorized by law to provide substituted consent for a *Covered Person*;
- A family member but only when *You* are unable to provide consent.

BALANCE BILLING
The *Maximum Allowed Amount* paid by *Us* to an *Out-of-Network Provider* may be less than the amount billed. Because *We* are not contracted with *Out-of-Network Providers*, the remainder of the fees they charge, if not fully covered by *Our* payment, may be billed to *You*.

BENEFITS
The maximum amount that will be allowed for a *Covered Service*. *Benefits* may be expressed in many ways, such as a dollar amount, number of days, or the number of services. Some *Benefits* are discussed in this *Contract*, but generally are described in *Your Schedule of Benefits*.

CLASS A SERVICES
These are considered preventive or diagnostic services, which include oral examinations, dental cleanings (prophylaxis), diagnostic evaluations, sealants and x-rays.

CLASS B SERVICES
These are basic services, which include restorative procedures such as fillings and tooth extractions.

CLASS C SERVICES
These are major services, which include endodontic services such as root canals, periodontal services such as scaling and planing, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as dentures.

CLASS D SERVICES
Orthodontic Services

COINSURANCE
The percentage of expenses for *Covered Services* that *You* are responsible to pay after meeting *Your Deductible*. The amount of *Your Coinsurance* depends on the plan *You* select. Refer to *Your Schedule of Benefits* to determine *Coinsurance* amounts. *Coinsurance* amounts that *You* pay, do not track towards satisfying *Your Annual Benefit Maximum* however the percentage that *We* pay does.

CONTRACT
This document issued to the *Contract Holder* consisting of this Evidence of Coverage, the *Schedule of Benefits*, the enrollment form, and any amendments, riders, or endorsements. This *Contract* indicates the terms and conditions of *Your* insurance coverage.

CONTRACT HOLDER
The person to whom the *Contract* is issued.

COVERED PERSON
A person who is eligible to receive *Benefit*s under this *Contract.*

COVERED SERVICE
Services, supplies, or treatment as described in this *Contract* which are performed, prescribed, directed, or authorized by a *Dental Provider.* To be a *Covered Service* the service, supply or treatment must be:

- Provided or incurred while the *Covered Person's* coverage is in force under this *Contract*;
- Covered by a specific *Benefit* provision of this *Contract*; and
- Not excluded anywhere in this *Contract*.

Covered Services are subject to any *Deductible* or *Coinsurance You* must pay.

DEDUCTIBLE
The dollar amount of a *Covered Service* that must actually be paid by the *Covered Person* during any calendar year before any *Benefit*s are payable. The amount of *Your Deductible* depends on the plan *You* select. Refer to *Your Schedule of Benefits* to determine *Deductible* amounts.

DENTAL PROVIDER
An individual licensed to practice dentistry in the state of Wisconsin who provides services within the scope of their license. To be a credentialed *Dental Provider* with CCHP, one must be licensed as either a Doctor of Dental Surgery (DDS) or Doctor of Medicine in Dentistry (DMD).

DEPENDENT
The *Contract Holder's* legal spouse, child, grandchild or the child or grandchild of the *Contract Holder's* spouse.

The term child includes any of the following:

- A natural child;
- A stepchild or a child for whom legal guardianship has been awarded to the *Contract Holder* or *Contract Holder's* spouse;
- A legally adopted child;
- A child placed for adoption with the *Contract Holder*;
- A child for whom dental care coverage is required through a Qualified Medical Child Support Order or other court or administrative order;

The term grandchild means a child of a covered *Dependent* child until the covered *Dependent* who is the parent turns 18 years of age.

A child listed above must be under 26 years of age at the time of enrollment to be eligible for coverage.

A *Dependent* will also include an unmarried child age 26 or older who meets the following criteria:

- The child is unable to hold a self-sustaining job due to intellectual disability or physical handicap;
- The child is chiefly dependent on *You* for support and maintenance;
- The child's incapacity existed before he or she reached age 26; and
- *Your* family coverage remains in force under this *Contract*.

A *Dependent* also includes an adult child who meets all of the following:

- The child is a full-time student, regardless of age, attending an accredited vocational, technical or adult education school, or an accredited college or university; or
- The child was under age 27 and called to federal active duty in the National Guard or in a reserve component of the U.S. Armed Forces while attending, on a full-time basis, an institution of higher education.

To be eligible for coverage under the *Contract*, a *Dependent* must reside within the United States.

DIAGNOSTIC IMAGING
X- rays or like procedures that are generally performed to aid in the diagnosis or monitoring of *Your* condition.

EFFECTIVE DATE
The applicable date coverage under this plan begins for a *Covered Person*.

ELIGIBLE PERSON
A person who meets the eligibility requirements specified in both the application and this *Contract*.

IN-NETWORK PROVIDER
A *Provider* of dental services that has a participation agreement in effect (either directly or indirectly) with CCHP. For a full listing of our *In-Network Providers*, please see our provider directory at [chorushealthplans.org].

IN-NETWORK BENEFITS
Covered treatment, services, or supplies provided by an *In-Network Provider*.

MAXIMUM ALLOWED AMOUNT
The maximum amount of reimbursement *We* allow for a specific procedure. When *You* use an *In-Network Provider*, the provider cannot bill *You* for the difference between the M*aximum Allowed Amount* and the billed charge. When *You* use an *Out-of-Network Provider*, *You* are responsible for the difference between the *Maximum Allowed Amount* and the billed charge in addition to any applicable *Deductible* or *Coinsurance* amounts.

MAXIMUM OUT-OF-POCKET LIMIT
The sum of the *Deductible* amount and *Coinsurance* percentage of covered expenses, as shown in the Schedule of Benefits. After the *Maximum Out-Of-Pocket (MOOP) Limit* is met, *We* pay 100% of *Covered Services* expenses for the calendar year, up to the *Annual Maximum Benefit*. *Your* payment of *non-Covered Services* does not count toward satisfying the *Maximum Out-of-Pocket Limit*.

MEDICALLY NECESSARY ORTHODONTIA
Services to help correct severe handicapping malocclusions caused by cranio-facial orthopedic deformities involving the teeth. This Benefit does not apply for *Covered Persons* age 19 and over. See *Your* Schedule of Benefits for more detail.

OUT-OF-NETWORK BENEFITS
Non-emergency, *Medically Necessary* treatment, services, or supplies provided by an *Out-Of-Network Provider.* Services received by *Out-of-Network Providers* may result in being *Balance Billed.*

OUT-OF-NETWORK PROVIDER
A provider who is not identified in the most current published list of the *In-Network Providers* provided by CCHP. Services received by *Out-of-Network Providers* may result in being *Balance Billed.*

PREDETERMINATION
A process performed to determine whether the requested treatment or service is *Medically Necessary*, that such services are *Covered Services,* and an estimation of expected member cost-share. Predetermination if not a guarantee of benefits or coverage. See page 20 for additional information on the *Predetermination* process.

PRIOR AUTHORIZATION
A process performed to determine whether the requested treatment or service is *Medically Necessary*, that such treatment or service will be obtained in the appropriate setting, and/or will be a *Covered Service*. *Prior Authorization* is required for some *Covered Services*.

PROTECTED HEALTH INFORMATION
Any personal information that is created or received by CCHP that relates to the *Covered Person*'s physical or mental health or condition, treatment or for payment of health care services received by the *Covered Person.*

SERVICE AREA
A geographical area, made up of [6] counties ([Kenosha, Milwaukee, Ozaukee, Racine, Washington, Waukesha]), where *We* have been authorized by the state of Wisconsin to sell and market *Our* dental insurance plans. This is where *Our In-Network Providers* are located and where *You* will receive all of *Your* dental care services and supplies. For a full listing of *Our In-Network Providers* in *Our Service Area,* please see our provider directory at [chorushealthplans.org].

SCHEDULE OF BENEFITS
A document *You* receive upon enrollment with CCHP which outlines the cost-sharing benefits of *Your* specific plan. *Your* member responsibilities such as *Deductibles* and *Coinsurance* are outlined in the *Schedule of Benefits*, along with how each class of services is covered.

WE, US, OUR, OURS
CCHP, also referred to as CCHP or any third-party administrator.

YOU, YOUR, YOURS, YOURSELF
The person listed as the *Contract Holder***.**

ENROLLMENT PROVISIONS

You may enroll for coverage by completing and signing an application and paying any required premium prior to the *Effective Date*, during an enrollment period, described below. *Your* coverage under this *Contract* will begin on *Your Effective Date* if *We* have received *Your* first month's premium. *We* are not responsible for claims incurred when *You* or *Your Dependents* are not eligible for coverage. If *We* pay claims and later learn *You* or *Your Dependent(s)* were not eligible for coverage, *You* will be responsible for reimbursements to *Us* or the *Dental Provider. You* will also be responsible for attorney's fees and expenses that *We* incur in recovering *Our* payments.

***CONTRACT HOLDER* ELIGIBILITY**

You will become eligible for this *Contract* if *You*:

- Enroll for coverage by completing and signing an application;
- Are a Wisconsin resident and reside in *Our Service Area* defined in this *Contract*; and
- Meet the requirements for being a "qualified individual" under the Health Insurance Marketplace, including (but not limited to) each of the following:
    - *You* are a citizen or national of the United States or a non-citizen who is lawfully present in the United States.
    - *You* reasonably expect to be a citizen or national of the United States or a non-citizen who is lawfully present in the United States for the entire period for which enrollment is sought.
    - *You* are not incarcerated (other than incarceration pending disposition of charges).

***DEPENDENT* ELIGIBILITY**

Your Dependent is eligible for coverage under this *Contract* if *You* complete and sign an application for coverage that names the *Dependent* as *Your Dependent*.

ANNUAL OPEN ENROLLMENT PERIOD

Annual open enrollment period is the timeframe when *You* may enroll *Yourself* and *Dependents*, as determined by the Health Insurance Marketplace.

The annual open enrollment period starts [November 1 and runs through January 15.] If *You* select coverage during the annual open enrollment period on or before [December 15] the *Effective Date* of coverage will be January 1 of the following year.

SPECIAL ENROLLMENT PERIODS

You may enroll *Yourself* or a *Dependent* during a 60-day special enrollment period. To do so, *You* must complete an application for coverage, submit proof of *Your* special enrollment in writing, and pay any required premium during the period. *Your* (or *Your Dependent's*) *Effective Date* of coverage will be one of the following.

- If the special enrollment period is for birth, adoption, placement for adoption, or placement in foster care, the *Effective Date* of coverage will be the date of birth, adoption, placement for adoption, or placement in foster care.
- In the case of a newborn child, including the newborn of a qualified *Dependent* child, *Your* newly born child is covered from the day of birth.

- *You* are required to notify *Us* within 60 days of the child's birth. If *You* do not notify *Us* and do not pay additional required premiums within the 60 day time period, coverage will not continue, unless *You* make all past due payments, with the applicable state allowable interest rate, within one year of the child's birth.
- If there is no additional premium for the newborn, *We* still request notification of the birth of *Your* newborn child in order to have them added to the plan.

- If the special enrollment period is for marriage or loss of minimum essential coverage, the *Effective Date* of coverage will be the first day of the month following the date of marriage or loss of minimum essential coverage.
- If the special enrollment period is for any other reason, the *Effective Date* of coverage will be as follows:

Date *You* Select *Your* Plan	***Effective Date***
1st – 15th of the month	First day of the following month*
16th – last day of the month	First day of the second following month*

For example, if *You* select coverage on March 9th, *Your Effective Date* will be April 1. If *You* select coverage on March 20th, *Your Effective Date* will be May 1.

*If applying On-Exchange, the Health Insurance Marketplace may designate an earlier *Effective Date* of coverage in certain circumstances.

A *Contract Holder* must have coverage in effect for a *Dependent's* coverage to become effective.

Members of federally recognized tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders can enroll in coverage any time of year. There is no limited enrollment period for these individuals, and they can change plans up to once a month.

PAYMENT PROVISIONS

- **PREMIUMS**
  We determine the premium rates for this *Contract* and all subsequent premiums for all *Covered Persons* under this *Contract*. *We* may change the premium rates under this *Contract* when *Dependents* are added or deleted or annually, effective [January 1st] of each year.

  We will provide written notice of a premium rate change to the *Contract Holder* before the first day of the annual open enrollment period. However, when the premium rate is increased 25% or more for a payment period, *We* will provide written notice of the new premium rate to the *Contract Holder* at least 60 days before any change takes effect. The premium rate change takes effect on the first day of the payment period as described in the required notice.

  The due date of *Your* premium will be the first of the month and is indicated on *Your* billing statement, which will arrive monthly. In order to keep *Your* coverage in effect, *You* must pay *Your* premium by the end of the applicable grace period after *Your* premium due date.

- **GRACE PERIOD**
  Except for *Your* first premium, any premium not paid to *Us* by the due date is in default. However, there is a grace period beginning with the first day of the month *Your* premium payment is due.

  Your grace period is 31 days from the due date. If *We* do not receive *Your* full premium payment by the end of the one month day grace period, this *Contract* will terminate, with the last day of *Your* enrollment being the most current paid-to-date.

TERMINATION OF COVERAGE

This *Contract* shall terminate on the earliest of the following dates:

- The date indicated in the *Covered Person's* written request to terminate coverage under this *Contract*;
  - All terminations must be the day of the request or a future date. *We* do not allow requests for retroactive terminations.
- With respect to a *Contract Holder*, if *We* do not receive *Your* payment of premium by the end of the one month period, this *Contract* is terminated retroactively to *Your* most current paid-to-date.
- With respect to the *Contract Holder's* covered *Dependent* spouse and any *Dependent* stepchildren who are children of the *Contract Holder's* covered *Dependent* spouse, the premium due date coinciding with the date on which the *Contract Holder* is divorced or legally separated from such spouse or such marriage was annulled;
- With respect to the *Contract Holder*'s *Dependent* child, the premium due date coinciding with the date on which a *Dependent* child ceases to meet the definition of *Dependent*;
- The date the *Co*vered *Person* has committed an act of fraud or made an intentional misrepresentation of material fact under the terms of this *Contract,* as determined by *Us*;
- The date the *Contract Holder* no longer resides or lives in the *Service Area* or in an area in which *We* are authorized to do business. Coverage will be terminated only if coverage terminated uniformly without regard to any health status related factors of *Covered Person's*;
- The first date following 90 days advance written notice by *Us* to the *Covered Person* when *We* may lawfully discontinue offering policies of this type in the state of Wisconsin;
- The date this *Contract* ceases to be a *Stand Alone Dental Plan* and is decertified by the Health Insurance Exchange;
- The date *We* terminate as a *Stand Alone Dental Plan*; or
- With respect to a *Covered Person*, the date immediately following the *Covered Person's* death.

DEPENDENT TERMINATION

A child who meets the requirements set forth under the *Dependent* definition found in the Terms and Definitions section of this *Contract*, ceases to be eligible as a *Dependent* on the last day of the month in which the child turns 26 years of age, except for a child who is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and is chiefly dependent on the *Contract Holder* for support and maintenance.

We may ask *You* to supply us with proof of the medical certification of disability within 31 days of when coverage would have expired due to aging off the policy. *We* may also continue to ask for proof of disability in the future. If *You* do not provide proof of disability and dependency within 31 days of *Our* request, coverage for the dependent will terminate effective based on the aforementioned guidelines.

The *Covered Person* must reimburse *Us* for any *Benefits* that *We* pay for a child at a time when the child did not satisfy the conditions above.

REINSTATEMENT

If *You* request reinstatement of *Your Contract* within one year after it has been terminated for non-payment of premium, *We* reserve the right to accept or deny *Your* request for reinstatement, and *We* will notify *You* of *Our* decision within 45 days after *We* receive *Your* request. *Our* deposit of the submitted premium payment does not mean that the request for reinstatement has been accepted. If *We* decide to reinstate *Your Contract*, *We* reserve the right to make such reinstatement subject to any legally permissible provisions as endorsed on or attached to *Your Contract*, which *We* will fully and prominently disclose to *You*.

If *We* accept *Your* request, then *We* will reinstate *Your Contract* as of the date *We* accept *Your* premium. Claims for services performed between the date of termination and the *Effective Date* of reinstatement will not be covered. No premium is payable for that period except to the extent that the premium is applied to a reserve for future losses. If *We* deny *Your* request for reinstatement, *We* will reimburse the premium payment *You* sent with *Your* request for reinstatement.

Please note regarding the paying of premiums on non-effectuated or terminated policies: Payments of premium made beyond the due date, will be returned to *You* less any claims paid for any period during which *Your* policy was not active. *Our* acceptance of the premium beyond the due date does not constitute an activation or continuation of a non-effectuated or terminated policy.

Please note that if *Your* insurance was purchased though the Federal Health Insurance Marketplace, all reinstatement requests must be filed with the Federal Health Insurance Marketplace who can be contacted at [1-800-318-2596].

When *Your* coverage ends, *We* will pay claims for covered services that *You* received prior to the date that *Your* coverage expired. *We* will not pay any claims for covered services received after *Your* coverage has expired even if treatment for the condition that was being covered began prior to the termination of coverage.

COVERAGE PROVISIONS

MEMBER IDENTIFICATION CARD

When *You* are enrolled in coverage and have completed *Your* binder payment, *You* will receive a member identification card in the mail. *You* are required to show *Your* ID card before *You* receive services or care. Only a *Covered Person* who has paid the premiums under this *Contract* has the right to services or *Benefits* under this *Contract*. If anyone receives services or *Benefits* to which they are not entitled to under the terms of this *Contract*, he/she is responsible for the actual cost of the services or *Benefits*. If *You* lose *Your* card, *You* should order a replacement card through Customer Service by calling [1-833-695-5344].

ACCESSING CARE

CCHP has contracted with specific *Dental Provider*s who have agreed to accept a contracted rate for *Covered Services* they perform. The *Benefits* in this *Contract* are paid the same for covered services furnished by *In-Network Dental Provider*s and *Out-of-Network Dental Provider*s. However, *You* will usually have less member responsibility by utilizing *In-Network Providers*.

- **IN-NETWORK**
  In-Network Providers are those that are contracted with CCHP to participate in our dental network, in our 6 county *Service Area*. When *You* visit an *In-Network Dental Provider*, the provider discount will lower your out of pocket costs, however *You* will still be responsible for any *Deductible* or *Coinsurance*.

  To find an *In-Network Dental Provider*, visit our *Dental Provider* directory at [chorushealthplans.org].

- **OUT-OF-NETWORK**
  If *You* choose to access an *Out-of-Network Dental Provider*, *Benefits* will be determined based on the out-of-network benefit level. CCHP will pay its standard portion of the covered charges, and *You* will be responsible for the remaining balance between what we paid and what the *Dental Provider* charged, this includes any *Deductible* or *Coinsurance*.

Whether services are received in-network or out-of-network, *You* will be responsible for any member cost-share above the *Annual Benefit Maximum* and for any non-covered services.

Ultimately it is *Your* responsibility to ensure the *Dental Provider You* wish to utilize is in-network at the time and location at which *You* received services. In order to locate an in-network *Dental Provider*, please access the provider directory on *Our* website at [chorushealthplans.org] or contact Customer Service.

RELATIONSHIP BETWEEN CCHP AND NETWORK PROVIDERS

The relationship between *Us* and *Our In-Network Providers* is an independent contractor relationship. *In-Network Providers* are not agents or employees of *Ours*, nor is CCHP, or any employee of *Ours*, an agent or employee of an *In-Network Provider*.

Your Dental Provider is solely responsible for all decisions regarding *Your* care and treatment, regardless of whether such care and treatment is a *Covered Service*. *We* shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any *Injuries* suffered by a *Covered Person* while receiving care from any *In-Network Provider* or in any *In-Network Provider's* facilities.

NOT LIABLE FOR PROVIDER ACTS OR OMISSIONS

We are not responsible for the actual care *You* receive from any person. This *Contract* does not give anyone any claim, right, or cause of action against *Us* based on the actions of a *Dental Provider* of dental care, services, or supplies**.**

FILING A CLAIM

- ***IN-NETWORK PROVIDERS***

  You will not be required to file any claims for services *You* obtain directly from *In-Network Providers*. *In-Network Providers* will seek payment for *Covered Services* from *Us* and not from *You* except for applicable *Deductibles,* and/or *Coinsurance*. *You* may be billed by *Your Dental Provider* for any *non-Covered Services You* receive or when *You* have not acted in accordance with this *Contract*.

- ***OUT-OF-NETWORK PROVIDERS***

  When *You* receive *Covered Services* from an *Out-of-Network Provider*, the claim must be filed in a format that contains all of the information *We* require, as described below. The *Dental Provider* will likely file the claim for payment from *Us*, but ultimately *You* are responsible for submitting any claims for processing.

Claims for payment of *Covered Services* should be submitted within 90 days after the date of service. If *You* don't provide this information to *Us* within 15 months of the date of service, *Benefits* for that dental service will be denied or reduced, at *Our* discretion. The time limit does not apply if *You* are legally incapacitated.

A request for the payment of *Benefits* should include the following information:

- The *Contract Holder's* name and address
- The patient's name and age
- *Your* member ID number found on *Your* card
- The name and address of the *Dental Provider* rendering the *Covered Services*
- The name and address of any ordering *Dental Provider*
- A diagnosis from the *Dental Provider*
- An itemized bill from *Your Dental Provider* that includes the Current Dental Terminology (CDT) codes or a description of each charge
- The date the *Covered Services* were rendered

You should send the claim to the claims address on *Your* ID card.

International emergent claims may be considered for reimbursement by *Us* if they meet the qualifications of a *Covered Service* as laid out in this *Contract*. When submitting a claim for services rendered outside the United States, *You* will be responsible for translation of the claims into English.

DATE OF DENTAL PROCEDURE
The date a dental procedure is completed, is the day it will be incurred. *Covered Services* are considered for *Benefits* if they are incurred while the policy is active and a claim is filed within 15 months after the date on which the procedure incurred.

CCHP pays upon completion of a procedure. Removable dentures and bridges are considered completed when they are placed in a patient's mouth. Fixed partial dentures and crowns are considered completed when they are cemented in. Root canals are completed on the date the canals are permanently filled.

COORDINATION OF BENEFITS
We will coordinate with the payment of benefits under other group or individual dental benefits coverage *You* may have and the payment of dental costs.

Know What *Your* Plan Covers
We offer three different dental plans. Services that are under the *Covered Services* and Limitations section of this *Contract* may not be covered under *Your* plan. Please refer to the *Schedule of Benefits* for *Your* plan. *Covered Services* may be subject to *Deductible* and/or *Coinsurance*.

Child				
Plan Type	**Class A Services** (No Waiting Period)	**Class B Services** (No Waiting Period)	**Class C Services** (No Waiting Period)	**Class D Services** (No Waiting Period)
Premier	Covered	Covered	Covered	Covered
Standard	Covered	Covered	Covered	Covered
Essential	Covered	Covered	Covered	Covered

Adult				
Plan Type	**Class A Services** (No Waiting Period)	**Class B Services** (6 Month Waiting Period)	**Class C Services** (12 Month Waiting Period)	**Class D Services**
Premier	Covered	Covered	Covered	Not Covered
Standard	Covered	Covered	Covered	Not Covered
Essential	Covered	Not Covered	Not Covered	Not Covered

COVERED SERVICES AND LIMITATIONS

We provide *Benefits* for the following *Covered Services*. Please see the Coverage Exclusions section to fully understand what is and what is not a *Covered Service* under this *Contract*. The frequency of certain *Covered Services,* like cleanings, are limited.

Class A Services – Preventive and Diagnostic Services
There is no *Waiting Period* on the following services:

- Clinical oral examination
    - Limited to two per person per calendar year.
- X-rays
    - Complete series or Panoramic (Panorex)
        - Limited to one per person, including panoramic film, in any 36 consecutive months.
- Bitewing x-rays
    - Limited to one set per person per calendar year.
- Prophylaxis (cleaning)
    - Limited to two per person per calendar year.
- Topical application of fluoride
    - Covered only for children 18 and younger once per calendar year.
- Topical application of sealant, per tooth, for a person 18 years or younger
    - Limited to one treatment per tooth in any three calendar years.
- Space maintainers
    - Covered only for children 18 and younger.

Class B Services – Basic Services
There is no *Waiting Period* for children 18 and younger. The *Waiting Period* for adults to receive *Class B Services* is six months. Please note, *Class B Services* are not covered for adults under the Essential plan.

- Fillings:
    - Amalgam, composite, or resin
- Routine Extractions for:
    - Erupted tooth or exposed root
    - Erupted tooth that requires the removal of bone

Class C Services – Major Services
There is no *Waiting Period* for children 18 and younger. The *Waiting Period* for adults to receive *Class C Services* is 12 months. Please note, *Class C Services* are not covered for adults under the Essential plan.

- Crowns – Prefabricated stainless steel and resin based
- Crowns restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
    - Porcelain fused to high noble metal
    - Full cast, high noble metal
    - Three-fourths cast, metallic
    - Retainer crowns are covered for covered dependents that are 18 years and younger.
- Implant – The surgical placement of an implant body or framework, of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant.
    - Implant removal is covered only if the implant is not serviceable and cannot be repaired.
    - Implant services are excluded from coverage for adults.
- I.V. Sedation – Paid as a separate benefit only when medically necessary, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.
- Osseous surgery – Child coverage only
- Prosthesis over implant – A prosthetic device, supported by an implant or implant abutment is a *Covered Service*. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 60 consecutive months old, is not serviceable and cannot be repaired.
- Removable appliances
    - Complete (full) dentures, upper or lower
    - Partial dentures
    - Lower/upper, cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- Denture adjustments
- Inhalation of nitrous oxide
- Periodontal scaling and root Planing – Entire mouth
- Endodontic services such as root canals
- Pulp Cap
- Oral Surgery including surgical extractions of impacted teeth, pre and post-operative care.
    - Removal of impacted tooth – soft tissue, partially bony, completely bony

Class D Services – Orthodontic Services
Orthodontia coverage is only for children 18 years and younger. There is no *Waiting Period* for these services.

Each month of active treatment is a separate Dental Service. Covered Expenses include:

- Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.
- Continued active treatment after the first month.
- Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.
- Periodic observation of patient dentition to determine when orthodontic treatment should begin, at intervals established by the dentist, up to four times per calendar year.

We encourage *You* to work with *Your Dental Provider* for payment arrangements.

COVERAGE EXCLUSIONS

The following are not *Covered Services*. Contact Customer Service with any questions.

APPLIANCES

Appliances, restorations, or procedures for:

- Increasing vertical dimension;
- Restoring occlusion;
- Correcting harmful habits;
- Replacing tooth structure lost by attrition, erosion, abrasion, or abfraction;
- Correcting congenital or developmental malformations except in newly born children or in conjunction with Medically Necessary Orthodontic Services;
- Replacement, provisional and temporary services, treatment or supplies;
- Splints, unless necessary as a result of accidental injury.

Also excluded are:

- Replacement of lost, missing, or stolen appliances
- Repair of damaged orthodontic appliances

COSMETIC SERVICES

Dental Procedures, services, treatment or supplies that are determined to be partially or wholly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances. Veneers are excluded from coverage.

DIAGNOSTIC SERVICES AND IMAGING

Pre-diagnostic services, oral pathology laboratory procedures, and diagnostic tests and examinations. Imaging that is excluded includes but is not limited to:

- Cone Beam Imaging, MRI, and ultrasound procedures

EMPLOYMENT-RELATED OR EMPLOYER-SPONSORED

Dental Procedures, services, treatment or supplies which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not the *Covered Person* claims the benefits or compensation. This applies to services or treatments received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group.

MILITARY SERVICE

Care for military service-connected disabilities and conditions for which *You* are legally entitled to services and for which facilities are reasonably accessible to *You*. Services that are provided to members of the armed forces or to individuals in Veterans Administration facilities for military service related *Illness* or *Injury*, unless *You* have a legal obligation to pay.

MISCELLANEOUS

Any services, supplies, or treatments not specifically listed in this *Contract*, including the following:

- Services and supplies which are not provided or arranged by a *Dental Provider* and authorized for payment in accordance with CCHP's policies and procedures.
- Dental Procedures, services, treatment, or supplies not specifically covered under this policy.
- Services provided by a non-licensed *Dental Provider*.

- Services rendered prior to the *Effective Date* of *Your* coverage or incurred after the date of termination of *Your* coverage, except as provided elsewhere in this *Contract*.
- Services for which *You* otherwise would have no legal obligation to pay.
- Charges for failure to keep a scheduled appointment.
- Office infection control charges.
- Charges for completion of any insurance form or copying of medical records.
- Services rendered by a professional *Dental Provider* who is a member of *Your* immediate family. Immediate family is defined as *Your* spouse, child, stepchild, parent, sibling, son-in-law, daughter-in-law, mother in-law, father-in- law, sister-in-law, brother-in-law, or grandparent.
- Services that are submitted by two different professional *Dental Providers* for the same services performed on the same date for the same person.
- As a result of:
    - An *Injury, Illness*, disability, or condition resulting from or caused by:
        - Any act of declared or undeclared war, or
        - Being engaged in active military, reservists' duties, National Guard, or civilian auxiliary forces.
    - The *Covered Person* taking part in a riot.

ORTHODONTIA
Adult orthodontic services including Orthodontic braces, appliances and all related services.

PROSTHETICS
Prosthetics placed on *Covered Persons* under age 16.

TEMPOROMANDIBULAR JOINT DISORDER SERVICES
Diagnostic procedures and surgical or non-surgical treatment (including prescribed intraoral splint therapy devices) for the correction of temporomandibular joint disorders (TMJ) and associated muscles.

WAITING PERIOD
Certain *Covered Services* includes *Waiting Periods* which is a length of time in which a service will not be covered. There are no *Waiting Periods* on *Covered Services* for children 18 and younger. To see the Covered Services and Limitations section of this *Contract* for more information on which services have *Waiting Periods*.

WORKERS' COMPENSATION
Treatment or services as a result of an *Injury* or *Illness* arising out of, or in the course of, employment for wage or profit, if the *Covered Person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law.

OTHER DENTAL SERVICES NOT PROVIDED IN THIS POLICY
CCHP will not cover dental services beyond what is listed in this *Contract*, including the following:

- Caries susceptibility tests
- Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a *Dental Provider* for treatment in any such facility.
- Dental Procedures, services, treatment or supplies are excluded for:
    - Injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan.
    - Services resulting from a *Covered Person's* failure to comply with professionally prescribed treatment.

    - Not medically necessary or which do not meet generally accepted standards of dental practice.
    - Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. An example of this exclusion is treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.
    - Services which are experimental or investigational.
    - Specialized procedures and techniques for which there is not an associated Current Dental Terminology (CDT) Code approved by the American Dental Association.
- Overdentures- Excluded for adult only
- Preventive control programs including, but not limited to, oral hygiene instructions, plaque control, take-home items, prescriptions and dietary planning.
- Sealants provided to a *Covered Person* who is age 19 and over are excluded.
- Implant services provided to a *Covered Person* who is age 19 and over are excluded.
- Teeth Lost , Extracted or Missing Before A *Covered Person* Becomes Covered By This Plan: A *Covered Person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan.
- Use of material or home health aides to prevent decay, such as toothpaste, fluoride gels, dental floss, and teeth whiteners.

PREDETERMINATION

Predetermination of Benefits is a voluntary review of a *Dental Providers* proposed treatment plan and the cost-sharing responsibility that *You* may have. It is not *Prior Authorization* of a service and is not required for most services. Although not required, *Predetermination* of proposed treatment is advised whenever extensive dental work is recommended whereas charges are likely to exceed $500.

The *Predetermination* for review should be submitted to *Us* by your *Dental Provider* prior to treatment beginning. The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested. If there is a change in the treatment plan, a revised plan should be submitted.

CCHP will determine covered dental expenses for the proposed treatment plan. If there is no *Predetermination* of *Benefits*, *We* will determine covered dental expenses when *We* receive a claim.

Predetermination of *Benefits* is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

PRIOR AUTHORIZATION

Prior Authorization is a process by which CCHP evaluates the appropriateness of care and service for members with active coverage. The authorization of services or supplies is based on the information that is available at the time of the *Prior Authorization. Prior Authorization* does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of benefits are subject to all terms and conditions of this *Contract.* If *You* choose to receive a service that has been determined not to be a *Covered Service*, or has not been *Prior Authorized* though *Prior Authorization* is required, *You* will be responsible for paying all charges and no *Benefits* will be paid.

The *Prior Authorization* process is a requirement for the following services:

- *Medically Necessary Orthodontia*
- Surgical removal of impacted third molars
- IV Sedation

In-Network Dental Providers are responsible for obtaining *Prior Authorization* before they provide services to *You*. However, if a *Dental Provider* is not contracted with CCHP and provides services or if *Your Dental Provider* does not contact *Us*, it is ultimately *Your* responsibility to ensure *Prior Authorization* was obtained.

CCHP will determine covered dental expenses for the proposed treatment plan based on the information provided to *Us*. If there is no *Prior Authorization, We* will determine covered dental expenses when *We* receive a claim.

PROCESS FOR OBTAINING *PRIOR AUTHORIZATION*

You should ask *Your Dental Provider* to start the *Prior Authorization* process as soon as possible before the beginning of treatment. *We* require that *Prior Authorization* for requests is received by *Us* no later than 14 days before *Your* scheduled service or care*. In-Network Dental Providers* can submit a *Prior Authorization* request online through the provider portal at [chorushealthplans.org]. *You* or *Your Dental Provider* can contact Customer Service at 1-877-389-9870 with questions on the *Prior Authorization* process.

URGENT *PRIOR AUTHORIZATION* REQUESTS

If *You* are in need of an urgent *Prior Authorization* for services, please have *Your Dental Provider* submit the authorization request so that *We* are able to determine if it meets the expedited standard. If *Your* request is not deemed to be urgent, *We* will notify *You* within three days of *Our* decision. If the request does meet the urgency standard, *We* will make *Our* decision and notify *You* within three days of receiving the initial authorization. In the event that additional information is needed to make a determination, *We* reserve the right to extend *Our* decision by up to 14 days. However, *We* will only offer this extension if it is in *Your* best interest.

COMPLAINTS AND APPEALS

You have the right to complain about services offered through CCHP or the *Dental Providers* in *Our* network, or any other issue. *You* also have the right to file an appeal when *You* are unhappy with a decision that has been made by *Us*. At any time during the course of the complaint and appeal process, *You* may choose to designate an *Authorized Representative* to participate in the complaint and appeal process on *Your* behalf. Appointment of representatives is completed in accordance with *Our* privacy policies. A complaint is an oral expression of dissatisfaction. Complaints can involve many different issues, including but not limited to the following:

- Access-appointment availability
- Attitude
- Billing and financial
- Quality of practitioner office site: physical appearance, physical accessibility of office practice sites
- Concerns related to quality of care or discrimination
- Unprofessional treatment by professionals
- Medical record access and documentation
- Patient care clinical quality or outcomes
- Fraud, waste or abuse
- Privacy/HIPAA violations

WHAT TO DO IF YOU HAVE A COMPLAINT

Contact Customer Service at the telephone number shown on *Your* ID card. Customer Service representatives are available to take *Your* call during regular business hours, Monday through Friday. We will notify *You* of the outcome of *Our* investigation within 30 days.

APPEALS PROCESS

An appeal is a written request to review any decision regarding any complaint or any *Adverse Benefit Determination*. An *Adverse Benefit Determination* means any of the following:

- Any decision to rescind this *Contract*, and
- Any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a *Benefit*, based on any of the following:
    - A determination of *Your* or *Your Dependent's* eligibility,
    - The application of any utilization review,
    - A determination that the item or service is for Experimental or Investigational Treatment
    - A determination that the item or services is not *Medically Necessary* or appropriate.

You or *Your Authorized Representative* can file an appeal within three years of *Our* decision concerning any matter. To file a formal appeal, *You* or *Your Authorized Representative* should write down *Your* concerns and mail *Your* written appeal (in any form) along with copies of any supporting documents to Us.

Your written appeal can be emailed to [cchp-appeals@chorushealthplans.org] or mailed to the address listed below:

- Chorus Community Health Plans
  Attn: Appeals Department
  [P.O. Box 1997, MS 6280
  Milwaukee, WI 53201-1997]

We will send *You* a letter within five business days notifying *You* that the appeal was received. *Our* acknowledgment letter will advise *You* of:

- *Your* right to submit written comments, documents, or other information regarding the appeal,
- *Your* right to be assisted or represented by another person of *Your* choice,
- *Your* right to appear before the appeals committee in person or via teleconference. *You* will receive at least 7 calendar days' notice of the meeting.
- Availability of interpreter services during the appeal process, for non-English speaking and hearing impaired members.
- How to contact *Us* for scheduling or to provide additional information.

We will review the appeal, investigate, and provide *You* with a decision within 30 calendar days of receiving the appeal. In some cases, an extension may be necessary and *You* will be notified accordingly. The total time for resolution will be no more than 45 days from the date the appeal was received.

WHAT TO DO IF YOUR APPEAL REQUIRES IMMEDIATE ACTION

A request for an urgent appeal will be considered if the application of the time period for making a non-urgent determination:

- Could seriously jeopardize *Your* life, health, or *Your* ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of *Your* medical condition, would subject *You* to severe pain that cannot be adequately managed without the treatment that is the subject of the request, or
- If a physician with knowledge of the *Covered Person*'s medical condition determines that the appeal shall be treated as an expedited appeal.

We will determine whether *Your* appeal qualifies as being urgent based on the aforementioned criteria. If it does, *we* will investigate and respond to *Your* appeal. If *Your* appeal does not meet the qualifications of being urgent, it will follow the standard timelines set forth above.

The request for an urgent appeal does not have to be in writing. Urgent appeals will be resolved within 72 hours after receipt, or sooner as needed to accommodate the urgency of the situation. *You* will receive both verbal and written notification of the decision. To file an urgent appeal, call *Us* at [1-877-900-2247, option #3] or send *Your* request via fax to [1-414-266-4195].

WHAT TO DO IF YOU DISAGREE WITH OUR DECISION

You may try to resolve *Your* problem by taking the steps outlined above in the complaints and appeals process. *You* may also contact the Office of the Commissioner of Insurance, a state agency which enforces Wisconsin's insurance laws, and file a complaint. *You* can contact the Office of the Commissioner of Insurance by writing to:

- Office of the Commissioner of Insurance Complaints Department
  [P.O. Box 7873
  Madison, WI 53707-7873]

You can also call [1-800-236-8517] and request a complaint form, or *You* can file a complaint electronically with the Office of the Commissioner of Insurance at its website [http://oci.wi.gov/].

Please note that *Our* decision is based whether or not *Benefits* are available under the *Contract*. *We* do not determine if pending services are necessary or appropriate. That decision is between *You* and *Your Dental Provider*.

LEGAL PROVISIONS

YOUR* RELATIONSHIP WITH *US

In order to make choices about *Your* dental care coverage and treatment, *We* believe that it is important for *You* to understand how *We* interact with *Your* benefit plan and how it may affect *You*. *We* help finance or administer the benefit plan in which *You* are enrolled. *We* do not provide medical services or make treatment decisions. This means:

- *We* do not decide what care *You* need or will receive. *You* and *Your Dental Provider* make those decisions.
- *We* communicate to *You* decisions about whether *Your* benefit plan will cover or pay for the dental care that *You* may receive. The plan pays for covered dental services, which are more fully described in this Evidence of Coverage.
- The plan may not pay for all treatments *You* or *Your Dental Provider* may believe are necessary. If the plan does not pay, *You* will be responsible for the cost.

We may use individually identifiable information about *You* to identify for *You* (and *You* alone) procedures, products, or services that *You* may find valuable. *We* will use individually identifiable information about *You* as permitted or required by law, including in *Our* operations and in *Our* research. *We* will use de-identified data for commercial purposes including research. Please refer to *Our* Notice of Privacy Practices for details.

OUR* RELATIONSHIP WITH *DENTAL PROVIDERS

We do not provide dental care, services, or supplies, nor do *We* practice medicine. Instead, *We* arrange for *Dental Providers* to participate in a network and *We* pay *Benefits*. *In-Network Dental Providers* are independent providers who run their own offices and facilities. *Our* credentialing process confirms public information about the *Dental Provider's'* licenses and other credentials, but does not assure the quality of the services provided. They are not *Our* employees nor do *We* have any other relationship with network *Dental Providers* such as principal-agent or joint venture. *We* are not liable for any act or omission of any *Dental Provider*.

YOUR* RELATIONSHIP WITH *DENTAL PROVIDERS

The relationship between *You* and any *Dental Provider* is that of provider and patient.

- *You* are responsible for choosing *Your* own *Dental Provider*.
- *You* are responsible for paying, directly to *Your Dental Provider*, any amount identified as a *Covered Person's* responsibility, including *Deductible, Coinsurance*, and any amount that exceeds *the Maximum Allowed Amount*.
- *You* are responsible for paying, directly to *Your Dental Provider*, the cost of any non-covered dental service.
- *You* must decide if any *Dental Provider* treating *You* is right for *You*. This includes network *Dental Providers You* choose and *Dental Providers* to whom *You* have been referred.
- *You* must decide with *Your Dental Provider* what care *You* should receive.
- *Your Dental Provider* is solely responsible for the quality of the services provided to *You*.

NOTICE

We provide written notice regarding administration of the *Contract* to *You* as the *Authorized Representative* of the *Contract* and that notice is deemed given to all affected *Contract Holders* and their *Covered Dependents*.

INCENTIVES TO PROVIDERS
We pay *Network Practitioners* through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect *Your* access to health care.

We use various payment methods to pay specific *Network Practitioners*. From time to time, the payment method may change. If *You* have questions about whether *Your Network Practitioner's* contract with *Us* includes any financial incentives, *We* encourage *You* to discuss those questions with *Your Practitioner*. *You* may also contact *Us* at the telephone number on *Your* ID card. *We* can advise whether *Your Network Practitioner* is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

CCHP wants its members to get the best possible care when they need it most. To ensure this, *We* use a *Prior Authorization* process, which is part of *Our* Utilization Management program. Utilization Management decision-making is based only on appropriateness of care and service, available for those members who have active coverage. CCHP does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization or denials of coverage.

INCENTIVES TO *YOU*
Sometimes *We* may offer coupons or other incentives to encourage *You* to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is *Yours* alone but *We* recommend that *You* discuss participating in such programs with *Your Practitioner*. These incentives are not *Benefits* and do not alter or affect *Your Benefits*. Contact *Us* if *You* have any questions.

DISCOUNTED OR FREE NON-INSURANCE PROGRAMS
We may elect to furnish or participate in programs with other organizations that furnish *Contract Holders* who meet common criteria or requirements determined by *Us* with discount cards, vouchers, coupons, or other goods, services or programs that may be offered or provided to *Covered Persons* at no charge or a reduced charge for a period of time determined by *Us*. *We* may provide *You* with access to discounts with certain health care *Practitioners* and suppliers negotiated by *Us*.

STATEMENTS BY *COVERED PERSONS*
All statements made by a *Covered Person* shall, in the absence of fraud, be deemed representations and not warranties.

INTERPRETATION OF BENEFITS
We have the sole and exclusive discretion to do all of the following:

- Interpret *Benefits* under the *Contract*.
- Interpret the other terms, conditions, limitations, and exclusions set out in the *Contract*, including this Evidence of Coverage, the Schedule of *Benefits,* and any Riders and/or Amendments.
- Make factual determinations related to the *Contract* and its *Benefits*.

We may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the *Contract*.

In certain circumstances, for purposes of overall cost savings or efficiency, *We* may, in *Our* discretion, offer *Benefits* for services that would otherwise not be *Covered Services*. The fact that *We* do so in any particular case shall not in any way be deemed to require *Us* to do so in other similar cases.

ADMINISTRATIVE SERVICES

We may, in *Our* sole discretion, arrange for various persons or entities to provide administrative services in regard to the *Contract*, such as claims processing. The identity of the servicing entities and the nature of the services they provide may be changed from time to time in *Our* sole discretion. *We* are not required to give *You* prior notice of any such change, nor are *We* required to obtain *Your* approval. *You* must cooperate with those persons or entities in the performance of their responsibilities.

AMENDMENTS TO THE *CONTRACT*

To the extent permitted by law, *We* reserve the right, in *Our* sole discretion and without *Your* approval, to change, interpret, modify, withdraw, or add *Benefits* or terminate the *Contract*.

Any provision of the *Contract* which, on its *Effective Date*, is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which the *Contract* is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the *Contract* unless it is made by an Amendment or Rider which has been signed by one of *Our* officers. All of the following conditions apply:

- *Amendments* to the *Contract* are effective 31 days after *We* send written notice to the *Contract Holder.*
- *Amendments* that result in a reduction of *Benefits* will be effective after the *Contract Holder* has have received 60 days prior written notice.
- *Riders* are effective on the date *We* specify.
- No agent has the authority to change the *Contract* or to waive any of its provisions.
- No one has authority to make any oral changes or Amendments to the *Contract*.

INFORMATION AND RECORDS

We may use *Your* individually identifiable health information to administer the *Contract* and pay claims, to identify procedures, products, or services that *You* may find valuable, and as otherwise permitted or required by law. *We* may request additional information from *You* to decide *Your* claim for *Benefits*. *We* will keep this information confidential. *We* may also use *Your* de-identified data for commercial purposes, including research, as permitted by law. More detail about how *We* may use or disclose *Your* information is found in *Our* Notice of Privacy Practices.

By accepting *Benefits* under the *Contract*, *You* authorize and direct any person or institution that has provided services to *You* to furnish *Us* with all information or copies of records relating to the services provided to *You*. *We* have the right to request this information at any reasonable time. This applies to all *Covered Persons*, including *Covered Dependents* whether or not they have signed the *Contract*

Holder's enrollment form. *We* agree that such information and records will be considered confidential. *We* have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the *Contract*, for appropriate medical review or quality assessment, or as *We* are required to do by law or regulation. During and after the term of the *Contract*, *We* and *Our* related entities may use and transfer the information gathered under the *Contract* in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to *Our* Notice of Privacy Practices.

For complete listings of *Your* medical records or billing statements *We* recommend that *You* contact *Your Dental Provider*. *Dental Providers* may charge *You* reasonable fees to cover their costs for providing records or completing requested forms. If *You* request medical forms or records from *Us*, *We* also may charge *You* reasonable fees to cover costs for completing the forms or providing the records. In some cases, as permitted by law, *We* will designate other persons or entities to request records or information from or related to *You*, and to release those records as necessary. *Our* designees have the same rights to this information as *We* have.

WORKERS' COMPENSATION NOT AFFECTED

Benefits provided under the *Contract* do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

REFUND OF OVERPAYMENTS

If *We* pay *Benefits* for expenses incurred on account of a *Covered Person*, that *Covered Person*, or any other person or organization that was paid, must make a refund to *Us* if any of the following apply:

- All or some of the expenses were not paid by the *Covered Person* or did not legally have to be paid by the *Covered Person*.
- All or some of the payment *We* made exceeded the *Benefits* under the *Contract*.
- All or some of the payment was made in error.

The refund equals the amount *We* paid in excess of the amount *We* should have paid under the *Contract*. If the refund is due from another person or organization, the *Covered Person* agrees to help *Us* get the refund when requested.

If the *Covered Person*, or any other person or organization that was paid, does not promptly refund the full amount, *We* may reduce the amount of any future *Benefits* for the *Covered Person* that are payable under the *Contract*. The reductions will equal the amount of the required refund. *We* may have other rights in addition to the right to reduce future *Benefits*.

LIMITATION OF ACTION

No suit or action at law or in equity can be brought later than three years from the date when proof of loss is required to be furnished under this *Contract*.

SUBROGATION AND REIMBURSEMENT

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand, or right. Immediately upon paying or providing any *Benefits*, *We* shall be entitled to subrogation in all rights of recovery (recovery of benefits paid when other insurance provides coverage), under any legal theory of any type for the reasonable value of any services and *Benefits We* provided to *You*, from any or all of the following listed below.

In addition to any subrogation rights and in consideration of the coverage provided by this certificate, *We* shall also have an independent right to be reimbursed by *You* for the reasonable value of any services and *Benefits We* provide to *You*, from any or all of the following listed below.

- Third parties, including any person alleged to have caused *You* to suffer injuries or damages.
- Any person or entity who is or may be obligated to provide *Benefits* or payments to *You*, including *Benefits* or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to *You* on any equitable or legal liability theory. These third parties and persons or entities are collectively referred to as "Third Parties".

These Subrogation and Reimbursement rights granted to *Us* shall not apply until such time as *You* have been "made whole". *You* are made whole if a claim results in payment to *You*, by way of settlement, compromise, or judgment of an amount less than the combined total of any available third party payments, including liability, uninsured, or underinsured motorist policy proceeds. In the event of the settlement or compromise of a disputed claim, *You* are made whole when a claim results in payment for less than the total available third party proceeds after reducing *Your* total damages to account for any contributory negligence attributable to *You*. *We* and *You* each have a right to a hearing by a trial judge if there is a dispute as to the amount of contributory negligence reasonably attributable to *You*.

You agree as follows:

- That *You* will cooperate with *Us* in protecting *Our* legal and equitable rights to subrogation and reimbursement, including:
    - Providing any relevant information requested by *Us*.
    - Signing and/or delivering such documents as *We* or *Our* agents reasonably request to secure the subrogation and reimbursement claim.
    - Responding to requests for information about any accident or injuries.
    - Making court appearances.
    - Obtaining *Our* consent or *Our* agents' consent before releasing any party from liability or payment of medical expenses.
- That *We* have the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- That no court costs or attorneys' fees may be deducted from *Our* recovery without *Our* express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and *We* are not required to participate in or pay court costs or attorneys' fees to the attorney hired by *You* to pursue *Your* damage/personal *Injury* claim.
- That after *You* have been fully compensated or made whole, *We* may collect from *You* the proceeds of any full or partial recovery that *You* or *Your* legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.

- That *Benefits* paid by *Us* may also be considered to be *Benefits* advanced.
- That *Yo*u agree that if *You* receive any payment from any potentially responsible party as a result of an *Injury* or *Illness*, whether by settlement (either before or after any determination of liability), or judgment, *You* will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of *Your* duties hereunder.
- That *You* or an authorized agent, such as *Your* attorney, must hold any funds due and owing *Us*, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health *Benefits* or the instigation of legal action against *You*.
- That *We* may set off from any future *Benefits* otherwise provided by *Us* the value of *Benefits* paid or advanced under this section to the extent not recovered by *Us*.
- That *You* will not accept any settlement that does not fully compensate or reimburse *Us* without *Our* written approval, nor will *You* do anything to prejudice *Our* rights under this provision.
- That *You* will assign to *Us* all rights of recovery against Third Parties, to the extent of the reasonable value of services and *Benefits We* provided, plus reasonable costs of collection.
- That *Our* rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom *You* are seeking recovery, to be paid before any other of *Your* claims are paid.
- That *We* may, at *Our* option, take necessary and appropriate action to preserve *Our* rights under these subrogation provisions, including filing suit in *Your* name, which does not obligate *Us* in any way to pay *You* part of any recovery *We* might obtain.
- That *We* shall not be obligated in any way to pursue this right independently or on *Your* behalf.
- That in the case of *Your* wrongful death, the provisions of this section will apply to *Your* estate, the personal representative of *Your* estate and *Your* heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a *Dependent* child who incurs a *Sickness* or *Injury* caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's *Injury*, the terms of this subrogation and reimbursement clause shall apply to that claim.

OTHER PROVISIONS

ENTIRE *CONTRACT*
This Evidence of Coverage is issued to the *Contract Holder*. The entire contract of insurance includes the Evidence of Coverage, the schedule of *Benefits*, a *Covered Person's* enrollment form, and any riders and endorsements.

***CONTRACT* CHANGES**
No change in the *Contract* will be valid unless approved by one of *Our* executive officers and included with or issued as a supplement to this *Contract*. No information provided by the Customer Service department will change *Your* coverage, obligations, or responsibilities under the *Contract*. No agent or other employee of *Our* company has authority to waive or change any plan provision or waive any other applicable enrollment or application requirements.

CLERICAL ERROR
If a clerical error is made by *Us*, it will not affect the insurance to which a *Covered Person* is entitled.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this *Contract*.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, *We* will refund the difference. If the premium was underpaid, the difference must be paid to *Us* within 60 days of *Our* notifying *You* of the error.

CONFORMITY WITH STATE STATUTES
If this plan, on its *Effective Date*, is in conflict with any applicable federal laws or laws of the state where it is issued, it will be changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary.

ENFORCEMENT OF PLAN PROVISIONS
Failure by *Us* to enforce or require compliance with any provision within this plan will not waive, modify, or render any provision unenforceable at any other time, whether the circumstances are the same or not.

MISSTATEMENTS
If a *Covered Person's* material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, *We* may require payment of past premiums at the adjusted rate to continue coverage. If the *Covered Person's* age is misstated and coverage would not have been issued based on the *Covered Person's* true age, *Our* sole liability will be to refund all of the premiums paid for that *Covered Person's* coverage, minus the amount of any *Benefits* paid by *Us*.

RECISSION OF INSURANCE AND/OR DENIAL OF CLAIM
Within the first two years after the *Effective Date* of coverage, *We* have the right to modify *Your Contract* of insurance coverage and/or deny a claim for a *Covered Person* if the enrollment form contains an omission or misrepresentation, whether intended or not, which *We* determine to be material. *We* also reserve the right to rescind a *Contract* of insurance and/or deny a claim if the *Covered Person* has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact at any time during the coverage period.

FORUM
Any lawsuits or disputes arising under the terms of the *Contract* must be brought to the United States District Court for the Eastern District of Wisconsin.

ASSIGNMENT OF BENEFITS
This coverage is just for *You* and/or *Your* eligible *Dependents*. *Benefits* may be assigned to a *Dental Provider* to the extent allowed by Wisconsin insurance law and by other provisions in this *Contract*.

CHORUS
COMMUNITY HEALTH PLANS

Photo courtesy of Visit Milwaukee

© 2022 Chorus Community Health Plans. All rights reserved. HP_COR_404 0522