



Individual Dental Yellow Option

Ascent Benefits Company - Plan 5



SUMMARY OF BENEFITS – Plan 5

Ascent Benefits Company, Inc.

Individual Dental Coverage Policy

Summary Effective Date: 09/01/2009

Group : 1004

Group Name : Individual Coverage Plan 5- Yellow

Effective Date : First of the month following the approval of your completed enrollment form and down payment.

Contract Year : Twelve month period, beginning on your Effective date.

This is the twelve (12) month period for which these Contract benefits apply

Benefit Year : Twelve month period, beginning on your Effective date.

Benefit Year means the annual period specified in the Individual Dental Contract for calculation of benefits, co-payment, and deductibles under This Contract.

Age Limits : Child: 19 Student: 24

Deductible : \$25.00 per person

Annual Benefit Year Maximum: \$500.00

REFER TO THE DENTAL COVERAGE POLICY'S DESCRIPTION OF SERVICES FOR A MORE DETAILED DESCRIPTION INCLUDING LIMITATIONS AND EXCLUSIONS. BENEFITS SUBJECT TO ALL PROVISIONS, TERMS & CONDITIONS OF THE DENTAL COVERAGE POLICY.

Predetermination recommended for services over \$250.

Type 1 Preventive

100%

**Deductible does apply to these services

**No waiting period

Diagnostic

- Exams (Twice in a Benefit Year)

Preventive

- Topical Application of Fluoride (children to the age of eighteen (18) - once in a benefit year)
- Routine Cleanings (limited to twice in a benefit year)
- Sealants for children (Once in a three (3) year period for permanent molars & bicuspids up to age nineteen (19).

Type 2 Basic

100%

**Deductible does apply to these services

Restorative

- X-rays: Bitewings (Once in a Benefit Year) and single tooth.

** If within the past 60 days you have been covered under an Ascent group plan AND have had continuous coverage under that plan for a minimum of 12 months, waiting periods may be waived.

ASCENT BENEFITS COMPANY, INC.
NOTICE OF PRIVACY AND INFORMATION PRACTICES

THIS NOTICE IS EFFECTIVE AS OF APRIL 14, 2003

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

At Ascent Benefits Company, Inc. (Ascent), we use health information and personal information about you to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. We NEVER sell any information we collect while processing transactions on your request while you are covered under Ascent or after your coverage ends.

Ascent collects information about you (examples include full-time student status, handicap status, guardianship status documents) through the enrollment process and through the payment of claims. This information collection, use, and disclosure is how Ascent's customer service representatives, claims processors, and other staff properly administer group dental contracts as well as communicate to dental offices. Ascent is permitted to use or disclose protected health information to the individual, pursuant to an authorization, and for treatment, payment, or health care operations. We may use and disclose your protected health information in these instances.

You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then Ascent may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care. You may opt out of this provision by sending us a written statement.

Ascent, as a health insurance issuer, with respect to a group health plan, may disclose protected health information to the sponsor of the plan.

We will share your protected health information with third party “business associates” that perform various activities (e.g., printing of checks and explanations of benefit [EOBs]) for Ascent. Whenever an arrangement between Ascent and a business associate involves the use or disclosure of your protected health information, we will have a written contract with the business associate that contains terms to protect the privacy of your protected health information.

Authorizations

We provide information without obtaining your authorization, when required by law (such as for law enforcement in specific circumstances), when requested by the Colorado Department of Insurance or when required by the Secretary of Health and Human Services. Other examples include, public health and health oversight activities, judicial and administrative proceedings, coroners and medical examiners, Governmental health data systems, directory information, banking and payment processes, research purposes, emergency circumstances, next-of-kin, specialized classes (military purposes, Dept. of Veterans Affairs, the intelligence community, Dept. of State), and other requirements defined by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

In situations other than routine administration or as described above, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. This request can be made at any time, in writing, except to the extent that Ascent has taken an action in reliance on the use or disclosure indicated in the authorization.

You can be assured that when processing or servicing a transaction at your request, only the minimum necessary information regarding your account or personal history information will be used or disclosed, as permitted by law. Ascent applies the “most stringent” law to your health information. That means that you are afforded the most protection whether that is from Federal or State Regulation. Greater individual rights of access and amendment provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

When You Get A Notice

This notice must be provided no later than the compliance date to individuals then covered by the plan and within 60 days of a material revision to the notice, to individuals then covered by the plan. No less frequently than once every three years, the health plan must notify individuals then covered by the plan of the availability of the notice and how to obtain the notice. The health plan may provide the notice to the named insured of a policy under which coverage is provided to the named insured and one or more dependents. If you requested or agreed to receive this notice electronically, you may obtain a paper copy upon request.

We may change our policies at any time. However, before we make a material revision to our policies, we will change our notice of information practices and deliver the revised notice as required by law. The revised notice will be effective for all protected health information that we maintain at that time. Except when required by law, a material change to any term of the notice may not be implemented prior to the effective date of the notice in which such material change is reflected. You can also request a copy of our notice at any time by accessing our website at www.ascentbenefits.com or by calling the office and requesting that a revised copy be sent to you in the mail. For more information about our privacy practices, please contact the person listed below.

Individual Rights

In most cases, you have the right to request and to receive a copy of health information about you that we use to make decisions about you. If you request copies, you will be charged \$0.10 (10 cents) for each page. You also have the right to request and to receive a list of instances where we have disclosed health information about you. Ascent does not routinely record the identity of the recipient of the information that we have disclosed to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract and to perform quality assurance. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information to confirm eligibility and benefits, to pay claims from your dentist, to coordinate benefits with other carriers, to administer the group dental contract, to perform quality assurance, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

You may request in writing to receive communications of protected health information from Ascent by alternative means or at alternative locations. You must clearly say in the statement that disclosure of all or part of the information to which the request pertains could endanger you. We must accommodate reasonable requests that can be conditioned upon the specification of an alternative address or other method of contact.

Complaints

If you are concerned that we have violated your private rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the Colorado Department of Insurance. The person listed below can provide you with the appropriate address upon request.

You may also file a complaint to the Secretary. In accordance with Federal Regulations (§160.306), your complaint must be filed in writing, either on paper or electronically. You must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the applicable standards, requirements, and specifications. A complaint must be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless this time limit is waived by the Secretary for good cause. We will not retaliate against you for filing a complaint.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints or desire additional information, please contact:

Customer Service – Privacy Officer
Ascent Benefits Company
P.O. Box 41698
Phoenix, Arizona 85080-1698
Phone: (888) 651-7643
Email: customerservice@ascentbenefits.com.

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This Dental Coverage Policy should be read in conjunction with the Summary of Benefits. The Summary of benefits included in this booklet is an outline of the benefits for your policy with Ascent Benefits Company, Inc. (Ascent). The benefits are subject to all provisions, terms and conditions of the policy.

This Dental Coverage Policy in conjunction with the Appeals Packet and application for coverage constitutes the complete document of insurance. This Dental Coverage Policy, which describes the benefit provisions, takes the place of any other Dental Coverage Policy issued to you on a prior date.

Even if your dentist has prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though the service is not expressly excluded in this Dental Coverage Policy. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.

WHO CAN BE COVERED UNDER THIS DENTAL COVERAGE POLICY

Eligible Policyholder

The person in whose name the policy is written.

Eligible Dependents

If you are enrolled for family coverage, the following dependents may be covered under this program:

- A. Your lawful spouse; and
- B. Your unmarried children under age nineteen (19) (or according to the maximum age limits stated in the Summary of benefits included in this Dental Coverage Policy) or those your lawful spouse, including newborn children, stepchildren, persons under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption with you in accordance with applicable state or federal law.

Student Status A dependent child will be eligible for coverage until age nineteen (19) or to age twenty-four (24) for full-time students financially dependent upon the parent attending an accredited school and enrolled in a minimum number of credit hours in accordance with the school's full-time student . Student status will be verified. Written verification of full-time student status should be submitted at each policy anniversary date. It shall be valid until the next periodic update. If verification is not received at initial enrollment, verification will occur when the first claim is received.

Handicapped Status A Policyholders dependent child who is medically certified as disabled and dependent upon the parent over the age of nineteen (19) may continue to be eligible as a dependent, if he or she is incapable of self-sustaining employment because of physical or mental incapacity that began before age nineteen (19), and is dependent on the subscriber for support and maintenance. Proof of incapacity must be provided to Ascent within thirty-one (31) days of a request, but not more frequently than once per year following the child reaching the applicable limiting age.

Military Status No children who are on active duty in military service are eligible for coverage under this Dental Coverage Policy.

WHEN DOES COVERAGE BEGIN?

Effective Dates

The policyholder is covered under this program:

- A. Upon approval of the enrollment documentation and remittance of premium payment. When received between the 1st and 10th of the month, coverage will be effective the first of the month immediately following. When received between the 11th and last day of the month, coverage will be effective the first day of the second month.
- B. After the Benefit Waiting Periods have been satisfied as outlined in the Summary of benefits.

Eligible Dependents are covered under this program:

- A. On the date the Policyholder's coverage is effective; or
- B. At an anniversary date allowing the policyholder to make coverage changes. Coverage is effective on the anniversary date.
- C. On the date the dependent is acquired, meaning: the birth, adoption, placement for foster care, placement for adoption with the Policyholder and for whom the application and approval procedures for adoption have been completed, a marriage that results in the spouse and stepchildren being added to coverage and required to be covered by court order.

D. After the Benefit Waiting Periods have been satisfied as outlined in the Summary of benefits.

ADDITIONAL INFORMATION ON EFFECTIVE DATES OF ENROLLMENT

If a Policyholder does not enroll his/her dependents when they are first eligible and later acquires a dependent as a result of marriage, birth, adoption, placement for foster care or placement for adoption, the dependent(s) may enroll for coverage at that time.

- A. If a Policyholder acquires a dependent due to marriage, the effective date of coverage of the eligible dependents(s) will be on the date the person becomes a dependent. The Policyholder must submit a completed Ascent approved enrollment form within thirty (30) days from the date of marriage. If there is a change in premium, it will be included in the first billing date after the change adjusted back to the effective month of the change.
- B. If a Policyholder acquires a dependent as a result of birth, adoption, placement foster care or placement for adoption, the effective date of coverage for the newly acquired dependent and any other eligible dependent(s), will be the date of birth, adoption, placement for foster care or placement for adoption. The Policyholder must complete and sign an Ascent approved enrollment form within thirty-(30) days. If there is a change in premium, it will be included in the first billing date after the change adjusted back to the effective month of the change.

An approved enrollment form must be submitted to add newborn or any adopted children, even if no additional premium is required. Ascent's claim payment system tracks deductibles, maximums and benefit information individually for each Covered Person. The name and other pertinent information, as included on the enrollment form, are required to process claims. Therefore, it is prudent to address this as soon as possible. The claims payment may be delayed and/or possibly denied if Ascent does not have the data on this dependent in the claims paying system and if premium has not been paid for this dependent.

- C. If a court or other administrative body orders that coverage be provided by a Policyholder, the effective date of coverage for this Covered Person will be the first billing date after Ascent receives the approved enrollment form. The Policyholder must submit a completed Ascent approved enrollment form within thirty (30) days after the court or other administrative order is issued. However, the effective date of coverage may be different if required by court order or applicable law.

Anniversary date

This policy is written for a period of 12 months from the policyholder's effective date. A Policyholder may elect to continue coverage or dis-enroll at any anniversary date

WHEN DOES COVERAGE END?

LOSS OF ELIGIBILITY

Coverage for the eligible Policyholder and/or eligible dependent will terminate on the last day of the month, or as designated by the Summary of benefits included in this Dental Coverage Policy. Examples of events that would trigger loss of eligibility include but are not limited to the following:

- A. Eligible Policyholders' eligibility ceases upon:
 - 1. Failure to satisfy any eligibility requirements listed in the Summary of benefits included in this Booklet;
 - 2. The date the Policyholder enters active duty in the military service;
 - 3. The date of death of the eligible employee;

4. Termination of the Dental Coverage Policy.
- B. Eligible Dependents' eligibility ceases upon:
1. The date the Policyholder no longer meets the eligibility criteria under the Dental Coverage Policy;
 2. The dependent spouse is no longer an eligible dependent as a result of a divorce decree;
 3. The date a self-sustaining, employable, dependent child between the ages of nineteen (19) and the limiting age is no longer a full-time student;
 4. The date a dependent child under the limiting age is no longer engaged in full-time humanitarian services (if included as an eligible dependent in the Dental Coverage Policy);
 5. The date of a dependent child's marriage;
 6. The date the dependent enters active duty in the military service;
 7. The date of the Policyholder's death;
 8. The date the Dental Coverage Policy terminates.

Rescission of Coverage

If there is fraud or a material misrepresentation on an enrollment form for coverage for any person ineligible to be covered by the dental plan, the coverage will be rescinded and will be considered as never having been in effect. Any premiums paid for coverage for the ineligible person will be refunded minus any claims paid for that person. Ascent is entitled to recover the claim payments that exceed the amount of premium paid.

Cancellation of the Dental Coverage Policy

Ascent may cancel the Dental Coverage Policy as follows:

- A. On an anniversary of the effective date; or
- B. If you do not pay the monthly premiums; or
- C. Upon a minimum of forty-five (45) days prior written notice to you if you become eligible for Ascent Benefits Company, Inc. group coverage through your employer;, or
- D. Upon a minimum of forty-five (45) days prior written notice to you for any other reason as outlined in the Dental Coverage Policy.

Claims Payment After policy Termination Ascent will not pay for any claim prior to the termination date but submitted by you or your dentist more than twelve (12) months after the date of termination of the Dental Coverage Policy. Ascent is not required to pay benefits for dental services provided after the cancellation date.

CAN COVERAGE BE EXTENDED AFTER TERMINATION?

Coverage After Termination

Benefits will not be paid for dental services provided after your coverage ends, including pre-determined services, except for multiple appointment procedures with a date of service before the termination of coverage which were completed within thirty (30) days from the date your coverage ended. Such benefits will be subject to all conditions specified in the Dental Coverage Policy.

CONVERSION COVERAGE

Who is Eligible for Conversion Coverage?

A Covered Dependent may enroll in conversion coverage upon the divorce or death of the Policyholder. The conversion coverage may include covered dependent children for whom the spouse has responsibility

for care and/or support. A Covered Dependent child may also enroll in conversion coverage upon reaching the limiting age, is no longer a full-time student, or on the date of the dependent child's marriage.

Ascent requires an Ascent approved enrollment form and the first premium payment within thirty-one (31) days for the conversion contract to become effective. The effective date of the conversion contract will be the day following termination of active coverage. There will be no evidence of insurability requirement.

Who Would Not Be Eligible for Conversion Coverage?

This conversion coverage is not available to a person covered by other dental benefits, which together with this conversion coverage would constitute duplicate insurance. This coverage also does not apply if the Policyholder terminates the Dental Coverage Policy as a result of a change to another insurance carrier.

HOW DOES THE PROGRAM WORK?

Using Your Dental Benefits

Visit the dentist of your choice. If you do not have a dentist, you may obtain a participating dentist directory by visiting our web site at www.ascentbenefits.com.

The contract between Ascent and your dentist may have changed. To maximize the value of your dental benefits, when making an appointment, confirm that your dentist is contracted with Ascent Benefits Company, Inc.

A Pre-determination or Pre-estimate Protects the Patient from Unanticipated Charges.

During your first appointment, advise your dentist that you are covered by Ascent under the Dental Coverage Policy number indicated on the Summary of benefits included in this booklet. Give the dentist your member identification number. Dependents must use the Policyholder's member identification number.

After an examination, your dentist will establish the treatment to be performed. If dental services over two hundred fifty dollars (\$250) are needed, ask your dentist to complete a pre-determination of benefits and submit the form to:

**Ascent Benefits Company
P.O. Box 43950
Phoenix, Arizona 85080-3950**

Ascent will verify your eligibility and determine the amount of benefits payable by your Plan. The pre-determination voucher will be returned by Ascent to the Participating Dentist with a copy to you. If you see a Non-participating Dentist, the pre-determination voucher will be returned by Ascent ONLY to you. The amount of the allowable fee, the amount of benefits payable by Ascent and the portion you are required to pay will be shown on the voucher and should be discussed with the dentist before extensive treatment is begun.

In order to be considered for coverage under this Dental Plan, the date of service for the dental treatment estimated in the pre-determination explanation of benefits must occur before the termination of coverage and be completed within thirty (30) days after the termination of coverage.

Pre-determinations are only valid for the procedure and for the dentist who submitted the pre-determination request and may not be transferred to any other dentist. All fee information is confidential. To estimate your out-of-pocket expenses ask your dentist to submit a pre-determination.

Notice to Policyholders and Dependents

All notices and correspondence regarding claims will be sent to the Policyholder by electronic mail or U.S. Postal mail to the last address in Ascent's enrollment records. It is recommended that the Policyholder notify Ascent of any change of name and/or address.

Notice of changes to the benefit plan will be provided to you forty five (45) days prior to the policyholder's anniversary date.

NETWORK OF MEMBER DENTISTS

Dentist: A natural person licensed to practice dentistry within the jurisdiction in which the service was provided.

NETWORK PROVISIONS:

Participating Dentist;

On the date of service, if the dentist is a participating dentist (a dentist who has signed an agreement with Ascent Benefits Company):

- A. The dental office will complete the claim forms and submit to Ascent for payment, pre-determination or coordination of benefits.
- B. You are required to pay only your coinsurance/co-payment/patient portion (if any) and/or deductible (if any) for covered benefits;
- C. Payment to the dentist will be based upon the lesser of the Participating Dentist's submitted fee, or Ascent's Maximum Reimbursable Allowance for services rendered. The Participating Dentist will not bill you more than the allowable fees;
- A. Participating Dentists must submit claims within twelve (12) months of the date of service for all services performed to ensure an accurate account of patient history of treatment and proper billing practices.
- B. The dentist agrees to abide by Ascent's benefit determination and administration policies, and agrees to accept payment directly from Ascent.

Non-Participating Dentist;

On the date of service, if your dentist is a Non-Participating Dentist (a dentist who has not signed an agreement with Ascent, or who has terminated as a Participating Dentist), benefits will be based on the lesser of billed charges or Ascent's Non-participating Dentist Maximum Reimbursable Allowance. Claim forms are available from our Ascent web site at www.ascentbenefits.com or your benefit administrator.

- A. You will be responsible to submit the claim form or pre-determination of benefits form to Ascent;
- B. You will be required to pay the difference between any amount billed by the dentist and Ascent's "allowable" fee. Ascent will reimburse you for benefits payable by your Employer Group's plan.
- C. The Non-Participating Dentist Maximum Reimbursable Allowance results, in most instances, is a reduced benefit when compared to the benefit paid for the same service to a Participating Dentist.

Outside the United States of America

If the dentist you see is outside of the United States, benefits will be based on the lesser of billed charges, or Ascent's Non-Participating Dentist Maximum Reimbursable Allowance. The subscriber is responsible for the full amount of the billed charges by the dentist. The claim form must include the billed charges in that country's currency and a conversion fee into United States dollars. The subscriber will be responsible for the submission of a copy of that dentist's license to practice dentistry in the county services were rendered. Ascent will reimburse the subscriber for the amount payable by the Employer Group Dental Contract in United States dollars. Benefits cannot be assigned to anyone.

Non-assignability of Benefits

The benefits of This Ascent Dental Coverage Policy are not assignable. You may not assign or transfer the rights to receive any portion of your benefits to any person or entity. If Ascent makes a payment that is inaccurate to you or makes an overpayment to you or on your behalf, Ascent is entitled to reimbursement from you or the provider of dental services or may offset the amount owed against a future claim. Inaccurate payments are not a waiver of any future rights of Ascent to deny payment for noncovered benefits.

Complaints About Dental Services

This dental program recognizes the right of each Covered Person to select a dentist of his or her own choosing. Ascent assumes no responsibility for the selection of dentists or for the quality of services received. However, all these parties are vitally interested in resolving questions that may arise concerning availability or quality of dental care. In fact, Ascent is committed to assuring, to the degree possible, that the professional services provided under this program do meet professionally established standards of dental health care. Ascent will, on its own or in consultation with a review committee of either the local and/or state dental society, thoroughly review the facts in each case and make a recommendation with regard to the issues brought to our attention. Policyholders who have questions concerning the services received either personally or by their dependents, should direct those questions to:

**Professional Services Department
Ascent Benefits Company
P.O. Box 41698
Phoenix, Arizona 85080-1698**

WHAT IS COVERED?

Benefit Payment Definitions

A. Policy Year

The policy Year is the twelve (12) month period beginning on the effective date of the policy and each yearly period thereafter. The Dental Coverage Policy is for one (1) year renewable terms. At any renewal period any portion of this Dental Coverage Policy may be amended, particularly the benefit provisions and rates. The twelve (12) month period for each policy year is outlined in the Summary of benefits included in this Dental Coverage Policy.

B. Benefit Year

Benefit Year is the time period for which benefits are paid; certain time limitations are tracked and the deductibles and maximum benefits described below are applied. A Benefit Year can be either a calendar year or a policy year. Please refer to the Summary of benefits included in this Dental Coverage Policy to determine the benefit period for your policy.

C. Deductibles

Deductible is the amount of covered dental expenses that you pay before the dental benefits are payable and applies to each Covered Person per Benefit Year. Only fees charged for covered dental services will be used toward the deductible. Please refer to the Summary of benefits included in this booklet for the dental services for which the deductible is applied.

How the deductible works:

1. When covered dental expenses equal to the deductible amount have been incurred and submitted to Ascent, the deductible will be satisfied.
2. Ascent will not pay benefits for covered dental services applied to the deductible.
3. There is one common deductible amount for the Participating and Non-participating Dentists.
4. The deductible is for a Benefit Year and is calculated on the date of service.
5. The lesser of the Ascent's allowance or billed charges for covered services will count toward the deductible.
6. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

D. Family Deductible Maximum

(Applies only if noted in the Summary of benefits included in this Dental Coverage Policy) Any amount applied to each Covered Person's deductible will count toward a family deductible maximum. Once the family deductible maximum is met, no further, deductible(s) is required. No family member may contribute more than the individual deductible amount toward the family maximum.

E. Benefit Specific Deductibles

Your benefit plan may include other deductibles that are in addition to your Benefit Year deductible. Examples of benefits which may require an additional deductible are TMJ and orthodontics. Refer to your Summary of benefits included in this Dental Coverage Policy.

F. Benefit Year Maximum

The Benefit Year Maximum is the total dollar amount that Ascent will pay for dental services rendered during any one (1) Benefit Year as per the Dental Coverage Policy. This Benefit Year Maximum applies to each Covered Person per Benefit Year. Please refer to the Summary of benefits for the dental services that are included in the Benefit Year Maximum.

The Benefit Year Maximum available to the Policyholder or covered dependent during a Benefit Year is shown in the Summary of benefits included in this booklet. This maximum will apply even if coverage is interrupted or if the Policyholder or any dependent has been covered both as an employee and a dependent. You cannot transfer all or any portion of your Benefit Year Maximum from person to person or year to year. All covered dental services that do not have a separate lifetime maximum will apply to the Benefit Year Maximum regardless of coinsurance level.

G. Specific Benefit Maximum

Some benefits may have a specific lifetime maximum. No benefits will be paid over the maximum amount specified in this benefit provision. The lifetime maximum amount is usually a separate benefit maximum and, as such, does not apply toward the annual maximum. The types of benefits, which may have a separate benefit maximum, include periodontics and orthodontics and temporomandibular joint (TMJ) procedures. Please refer to your Summary of benefits included in this Dental Coverage Policy for any procedures that have a Specific Benefit Maximum.

H. Benefit Waiting Periods

Some procedures may have a Benefit Waiting Period. The Summary of benefits included in this Dental Coverage Policy states the length of Benefit Waiting Periods and which dental services are subject to a Benefit Waiting Period. Charges incurred for dental services that are not covered during a Benefit Waiting Period will not be applied toward the deductible.

I. Dental Services

Expenses submitted to Ascent must identify the dental services performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature by narrative description. Ascent reserves the right to request x-rays, narratives and other diagnostic information, as needed, to determine benefits. We consider a temporary service to be an integral part of the final service.

J. Alternate Treatment

Occasionally, there are several professionally accepted methods to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced with either a fixed bridge or a partial denture. Ascent will make payment based on the allowance for the less expensive procedure provided that the less expensive procedure meets the accepted standards of dental treatment. Ascent's decision does not commit the patient to the less expensive procedure. However, if the patient and the dentist choose the more expensive procedure, the Policyholder is responsible for the additional charges beyond those paid or allowed by Ascent.

K. Date of Service

The date of service is indicated in the Covered Dental Services in this Dental Coverage Policy by type of procedure.

DESCRIPTION OF SERVICES

The following is a complete list of covered dental services. Ascent will not pay benefits for expenses incurred for any service not listed in this Dental Coverage Policy.

Only those services indicated as covered benefits on the Summary of benefits included in this Dental Coverage Policy are covered. Also noted in the Summary Benefits are the following:

- A. Deductibles and maximum benefits;
- B. The Benefit Year (calendar year or policy year);
- C. The Policy Year
- D. The categories of expenses indicating the coinsurance level at which these dental services will be covered (Routine, Basic or Major);
- E. The Benefit Waiting Period for each category of expense (if applicable).

The program includes these covered dental services when they are performed and completed by a licensed dentist in a dental office and when necessary and appropriate as determined by the standards of generally accepted dental practice. Covered dental services covered are subject to the Limitations and Exclusions described within this Dental Coverage Policy and in accordance with the Dental Coverage Policy

As deemed necessary on an individual basis, Ascent Benefits Company, Inc. may request radiographs and additional information for consultant review to determine if any procedures or services submitted for predetermination or for payment are:

- 1. a covered benefit under the Dental Coverage Policy
- 2. within the guidelines generally accepted by the American Dental Association and Ascent Benefits Company, Inc.'s Processing Policies

Even if your dentist has prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though the service is not expressly excluded in this Dental Coverage Policy. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.

COVERED DENTAL SERVICES

Orthodontics or dental care needed as a result of a child with cleft lip or cleft palate will be covered under this plan. The amount of coinsurance will be determined based on the classification of the procedures listed below.

The date of service is the date the procedure was performed unless otherwise noted below.

Examinations, evaluations or consultations

Two (2) of any combination of examinations, evaluations, or consultations during a Benefit Year. Includes those performed by a general dentist or specialist.

Diagnostic X-Ray Services

- A. Full -mouth x-ray series/ panoramic film, vertical bitewings is a benefit once in a five (5) year interval from the date this procedure was last performed.
- B. Bitewing x-rays are a benefit once in a Benefit Year.

Routine prophylaxis (scaling and polishing of teeth)

- A. Routine prophylaxis is a benefit twice in a Benefit Year.
- B. Routine prophylaxis and periodontal prophylaxis are considered to be interchangeable services. A patient must have documented periodontal history to receive a periodontal maintenance benefit (excluding full mouth debridement).

Please refer to Periodontics for full mouth debridement (difficult prophylaxis).

Fluoride treatment

- A. Fluoride treatment is a benefit once in a Benefit Year.
- B. Fluoride treatment is a benefit up to the age as stated in the Summary of benefits.

Space maintainers due to the premature loss of diseased posterior primary (baby) teeth.

- A. Space maintainers for posterior primary (baby) teeth are covered up to the age as stated in the Summary of benefits.
- B. Anterior space maintainers are not a covered benefit.

Sealants

- A. Sealants are a benefit once in a three (3) years interval from the date last performed.
- B. Sealants are a benefit for the occlusal surface (free from caries or restorations) on permanent bicuspids, first and second molars.
- C. Sealants are benefits up to the age as stated in the Summary of benefits.

Fillings

Fillings consisting of silver amalgam and, in the case of front teeth, composite tooth color fillings. (Composite tooth color fillings are a benefit on all teeth only if included in the Summary of benefits in this Dental Coverage Policy.)

- A. Fillings are a benefit once for each tooth surface in a twenty-four (24) month interval from the date this service was last performed on that specific tooth surface.

Pre-formed crowns

- A. Pre-formed crowns are a benefit once in a two (2) year interval from the date this procedure was last performed on specific primary (baby) teeth.
- B. Pre-formed crowns are a benefit once in a five (5) year interval from the date is procedure was last performed on specific permanent teeth.

Crowns and Onlays

The date of service for crowns and onlays is on the preparation date.

Crowns and onlays as follows, but only when the teeth cannot be restored with fillings due to severe loss of hard tooth structure as a result of decay or fracture. This excludes fractures or loss of tooth structure due to attrition, erosion, abrasion (wear), bruxism and damage to either hard or soft tissues as a result of a device worn in a tongue or lip piercing.

- A. Crowns and onlays are a benefit once in a five (5) year interval from the date this procedure was last performed on the same tooth.
- B. Crowns and onlays are a benefit only when no other professionally acceptable form of treatment can be performed.
- C. Crown build-ups are a benefit only when necessary to retain a cast restoration due to extensive loss of tooth structure.
- D. Crown build-ups (pin, bonded, or post and core) are a benefit once in a five (5) year interval from the date this procedure was last performed on the same tooth.
- E. Crowns and onlays are a benefit when provided for patients twelve (12) years of age or older. An allowance of a pre-formed crown will be benefited for patients under 12 years of age.
- F. Post and core buildups are not a benefit under an onlay.
- G. Veneers are not a covered benefit unless noted on the Summary of benefits and included in your Dental Coverage Policy. If veneers are not included, an alternate benefit of a crown will be provided, if the above criteria are met.
- H. Inlays are not a covered benefit unless noted on the Summary of benefits and included in your Dental Coverage Policy. If inlays are not included, an alternate benefit of a filling will be provided.

Endodontics

Benefits will be provided for necessary procedures for pulpal therapy in primary (baby) teeth (pulpotomy) and root canal treatment of infected tooth pulp (nerve) in permanent teeth.

- A. Endodontic benefits as described above are benefited once per tooth.
- B. Benefits for additional endodontic procedures, such as retreatment, are a benefit once in a three (3) year interval from the date of the last procedure for that tooth.
- C. The date of service is the date the Root canal is completed.

Periodontics

Benefits will be provided for treatment of diseases of the tissues supporting the teeth (gingival and/or alveolar bone).

- A. Periodontal Scaling and Root Planing is a benefit once in a two (2) year interval from the date this procedure was last performed on specific teeth or quadrants.
- B. Surgical periodontal treatment is a benefit once in a three (3) year interval from the date this procedure was last performed on those specific teeth or quadrants.
- C. Full Mouth Debridement (difficult prophylaxis) is a benefit once in a five (5) year interval from the date this procedure was last performed.

Prosthetic Services

Removable and Fixed Appliances

The date of service for a **removable appliance is the delivery date.**

The date of service for a **fixed appliance is the date of preparation.**

Provides bridges, partial dentures and full dentures for replacement of fully extracted or missing teeth.

- A. Adjustments to complete or partial dentures are limited to two (2) adjustments per denture, per twelve (12) months (after six months has elapsed since initial placement of the denture).
- B. Dentures, removable partials and fixed bridges are a benefit once in a five (5) year interval from the date this procedure was last performed.
- C. Relines and rebases are a benefit once in a two (2) year interval from the date this procedure was last performed.
- D. Temporary partial denture (flipper) for replacement of any of the permanent anterior teeth is a benefit once in a lifetime, per arch.
- E. A fixed prosthesis is not a benefit under the age of sixteen (16).

Oral and Maxillofacial Surgery Procedures

Benefits will be provided for extractions.

Post-treatment care for extractions is considered to be part of the procedure performed and a separate benefit is not provided.

General Anesthesia and Intravenous Sedation/Analgesia

Not for an anxiety, behavioral or management problem unless indicated in the Dental Coverage Policy and on the Summary of benefits included in this booklet, or, as stated for dependent children below:

Benefits for general anesthesia and intravenous sedation/analgesia will be provided only if the following conditions are met. That it is:

- A. Performed by a Dentist licensed to perform general anesthesia;
- B. Administered in a dental office;
- C. When performed in conjunction with surgical extractions.
- D. Necessary due to medically concurrent conditions, (i.e., neurological motor control problems) and documented by a medical physician;

General Anesthesia and Intravenous Sedation/Analgesia-additional provisions for dependent children.

Coverage for general anesthesia rendered in a hospital, outpatient surgical facility or dental office, performed by a Dentist licensed to perform general anesthesia, will be extended for a dependent child, if, in the treating dentist's opinion, the dependent child satisfies one or more of the following criteria:

- A. The child has a physical, mental, or medically compromising condition
- B. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy;
- C. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred;
- D. The child has sustained extensive orofacial and dental trauma.

Prior authorization may be required.

Emergency Palliative Treatment

Emergency treatment for the relief of pain.

Palliative treatment is not covered if definitive treatment is performed for the same problem on the same date. Examination and x-rays are not considered a relief of pain.

General Limitations - All Services

- A. If an eligible person with a covered condition selects a service that is not provided for under the terms of this Dental Coverage Policy, or selects specialized techniques rather than standard dental services, Ascent will pay the applicable percentage of the allowable fee for the standard covered dental service and the patient is responsible for the difference between what Ascent paid and the dentist's fee.
- B. Pre- and post-operative procedures are considered part of any associated covered service. Benefit will be limited to the covered amount for the covered services.
- C. Local anesthesia is considered a component of any procedure in which it is used.
- D. A temporary dental service will be considered an integral part of a complete service rather than a separate service, and separate payment will not be made for a temporary service unless otherwise included as a covered service of this policy.

- E. If a Covered Person transfers from the care of one (1) dentist to that of another dentist during a course of treatment, Ascent will not pay for more than the amount it would have paid for had only one (1) dentist rendered all the dental services during each course of treatment. Ascent will not pay for duplication of dental services.
- F. Even if your dentist has: prescribed, recommended or provided the service, it does not necessarily make the procedure eligible for benefits even though it is not expressly excluded in this Dental Coverage Policy. Regardless of dental or medical necessity, not all treatments and services recommended or performed by your dentist are covered benefits.
- G. If you or any of your dependents have received free services by or through a public program, Ascent will coordinate benefits based on submitted documentation.
- H. When an alternate benefit allowance is given, the alternate procedure allowed is subject to the time limitations of the procedure benefited.
- I. Implants, materials implanted or grafted into or onto bone or soft tissue, or removal of implants, are not a covered benefit except when covered by this policy. Refer to the Summary of benefits included in this Dental Coverage Policy.
- J. When a procedure is benefited, and then a new service is performed on the same tooth, it is subject to the time limitations of the prior service; therefore, benefits will be reduced on the new service.
- K. Sterilization fees are considered a component of any procedure in which it is used.
- L. If a covered service is subject to a benefit waiting period and the treatment begins prior to the completion of the waiting period, no benefit is allowed.

Exclusions

- A. Services for injuries or conditions which are compensable under Workman's Compensation or Employer's Liability Law, services which are provided the Covered Person by any Federal or State Government Agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or community agency except as pursuant to title XIX of the social security act.
- B. A service or procedure that is not generally accepted by the American Dental Association and Ascent's processing policies.
- C. A service or procedure that is not described as a benefit of this Dental Coverage Policy and included in the Summary of benefits in this Dental Coverage Policy.
- D. A method of treatment more costly than is customarily provided. Benefits will be based on the least expensive professionally accepted method of treatment.
- E. Dental and surgical services with respect to cosmetic surgery or dentistry for purely cosmetic reasons.
- F. Specialized techniques including but not limited to precious metal for removable appliances, precision attachments for partials or bridges, overdentures, overlays, implantology as well as procedures and appliances associated with the preceding procedures in addition to personalization and characterization.
- G. Charges for any health care not specifically covered under this Dental Coverage Policy including hospital charges, prescription drug charges, and laboratory charges or fees.
- H. Charges for dental services which are started prior to the date the person became covered under this Dental Coverage Policy or which are performed during the Benefit Waiting Period.
- I. Procedures, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: altering vertical dimension, replacing or stabilizing tooth structure lost by attrition, erosion, abrasion wear or bruxism, realignment of teeth, periodontal splinting, splinting, gnathologic recordings, equilibration, bite appliances or harmful habit appliances and/or other damage to either hard or soft tissues as a result of a device worn in a tongue or lip piercing is not a covered benefit.
- J. Temporary dentures, other than those provided in this Dental Coverage Policy.
- K. Study models, casts and other ancillary services not covered in this Dental Coverage Policy unless orthodontics is included as a covered benefit in the Summary of benefits.

- L. Travel time and related expenses.
- M. Orthodontic services except when covered by this Dental Coverage Policy and included in the Summary of benefits.
- N. Direct diagnostic or surgical and non-surgical treatment procedure applied to body joints or muscles, temporal mandibular joint (TMJ) or temporal mandibular disturbances (TMD), except when covered by this Dental Coverage Policy and included in the Summary of benefits.
- O. Ascent will not pay for any claim submitted more than twelve (12) months from the date of service or twelve (12) months after the termination of this Dental Coverage Policy whichever comes first.
- P. Ascent will not pay for any adjustments to previously received claims, including submissions of additional information, submitted more than twelve (12) months from the initial payment date or initial date issue date of the requested information.
- Q. Experimental or transitional procedures or any procedure other than those covered services.
- R. Myofunctional therapy or speech therapy.
- S. Services not performed in accordance with the laws of the State of Colorado, services performed by any person other than a person authorized by dental license to perform such services, or services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition as explained.
- T. Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records.
- U. Replacement of lost, stolen or damaged dental appliances.
- V. Procedures or services performed in conjunction with uncovered dental services.
- W. All other services not specified as covered dental service.

WHAT ELSE DO I NEED TO KNOW ABOUT CLAIMS PAYMENT?

Claims Inquiry

A toll free number is available for your use in calling Ascent to inquire about claims, claim payment status or to check on a specific dentist's status with regard to participation with Ascent. Calls should be made to 888-651-7643

Coordination of Benefits

Ascent coordinates the benefits under this program with you or your dependents' benefits under any other managed care program or insurance policy. Benefits under one (1) of these programs may be reduced so that your combined coverage does not exceed the maximum plan allowance or non-participating dentist allowable fee for the covered service. If this plan is the "primary" program, Ascent will not reduce benefits, but if the other program is primary, Ascent may reduce benefits. The reduction will be the amount paid under the terms of the primary program if it exceeds Ascent's maximum plan allowance. Refer to Covered Dental Services in the Summary of benefits included in this Dental Coverage Policy.

Determination of Primary Program

If a person is eligible for benefits under two (2) or more programs and more than one (1) of the programs provides coverage for an allowable benefit, Ascent will pay according to the Determination of the Primary Program stated below:

- A. The program covering the patient as a subscriber is primary over a program covering the patient as a Covered Dependent.
- B. When the patient is a dependent child, then the birthdays of the parents determine which program is primary. The program of the parent whose birthday (month and day, not year) occurs earlier in a

calendar year is primary and will pay its benefits first. The program covering the parent whose birthday occurs later in the year is secondary. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

- C. When the parents of a dependent child are legally separated or divorced the order of benefit determination is;
- a. The program covering the parent with legal custody.
 - b. The program covering the spouse of the parent with custody (i.e. stepparent)
 - c. The program of the parent not having legal custody
 - d. The program covering the spouse of the parent not having legal custody
- However, if there is a court decree assigning the responsibility for healthcare expenses of the child to one (1) parent, then the program covering that parent is primary or that parent's spouse if the assigned parent has no coverage.
- D. If the patient is a member of a pre-paid dental plan or other capitation plan and is also a Covered Person under this Employer Group Dental Contract then this Employer Group Dental Contract is primary, without regard to the existence of such other plan. Ascent will not be obligated to pay, however, for any dental services that are covered without charge under the prepaid or other capitation plan or to pay in excess of the amount of the co-payment obligation for the particular service under the prepaid or other capitation plan.
- F. If a person whose coverage is provided under a right of continuation pursuant to federal or state law and also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.
- G. The program covering the patient as an employee (or as that employee's dependent) is primary over the program covering the patient as a laid off or Retired Employee (or that employee's dependent).
- H. If the above rules do not apply, or if there are two (2) "primary" coverage plans due to retirement, then the program covering the patient longer is primary.
- I. If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.

How we Pay Claims When We Are Primary

When Ascent is the primary plan, we will pay the benefits provided by your contract, just as if you had no other coverage.

How we Pay Claims When We Are Secondary

Ascent will be secondary whenever the rules do not require us to be primary. When Ascent is the secondary plan, payment will not be made until after the primary plan has paid its benefits. Ascent will then pay part or all of the allowable expenses left unpaid. An "allowable expense" is a dental service or expense covered by one of the plans, including copayments and deductibles.

- A. If there is a difference between the amount the plans allow, we will base our payment on the higher amount. However, if the primary plan has a contract with the provider, our combined payments will not be more than the contract calls for. Health maintenance organizations (HMO) and preferred provider organizations (PPO) usually have contracts with their providers.
- B. We will determine our payment by subtracting the amount the primary plan paid from the amount we would have paid if we had been primary. We will use any savings to pay the balance of any unpaid allowable expenses covered by either plan.
- C. If the primary plan covers similar kinds of health care, but allows expenses that we do not cover, we will pay for those items as long as there is a balance in your benefit reserve, as explained below.
- D. We will not pay an amount the primary plan didn't cover because you didn't follow its rules and procedures. For example, if your plan has reduced its benefit because you did not obtain pre-certification, we will not pay the amount of the reduction, because it is not an allowable expense.

Benefit Reserve

When we are secondary we often will pay less than we would have paid if we had been primary. Each time we “save” by paying less, we will put that savings into a benefit reserve. Each family member covered by this plan has a separate benefit reserve.

- A. We use the benefit reserve to pay allowable expenses that are covered only partially by both plans. To obtain a reimbursement, you must show us what the primary plan has paid so we can calculate the savings.
- B. To make sure you receive the full benefit or coordination, you should submit all claims to each of your plans.
- C. Savings can build up in your reserve for one year. At the end of the year any balance is erased, and a fresh benefit reserve begins for each person the next year as soon as there are savings on their claims.

Right to Receive and Release Necessary Information

Ascent may release or obtain information from any insurance company or other person(s) as necessary to meet the “Coordination of Benefits” provisions of this policy. Ascent will determine the existence of, or amount payable under any other program, through the eligible person claiming benefits under this Dental Coverage Policy.

Right of Recovery

Ascent will recover any payment made that is more than the obligation determined by the rules of the Coordination of Benefits provision.

Provisions Required by Law

Before approving a claim, Ascent will be entitled to receive, to such extent as may be lawful, from any attending or examining dentist who is providing dental services to a Covered Person, any information and records regarding the examination and treatment of a Covered Person, as may be required to administer the claim. Ascent will in every case hold such information and records confidential. Ascent takes confidentiality very seriously and has various processes in place to ensure that sensitive or confidential information is safeguarded and that the release of such information is made only to facilitate coverage and in accordance with state and federal laws.

The release of information is made only to facilitate coverage. Ascent will not release information to spouses, relatives, attorneys, or others purporting to be the representative without your written consent. If you wish to authorize someone to have access to information, you must send a written request. You may visit our website, www.ascentbenefits.com or call Ascent’s Customer Service Department to request an Authorization to Disclose or an Authorized Representative Form. Once Ascent receives the form, it will release information to the person you have designated. Ascent may also limit release of information to the parent of dependent children who have reached the age of majority and are not subject to guardianship or conservatorship, even when such children are covered under the parent’s policy.

When the Policyholder is not a custodial parent of a child who is covered because of a court administrative order to provide health benefits that include dental coverage to that child, Ascent will provide benefit information to the custodial parent, permit the custodial parent to submit claims for the child and make payments directly to the custodial parent, provider or state agency as applicable. Under Colorado law, both parents have equal rights of access to information about their children, unless there is a court or other administrative order denying such access. Absent a copy of such order and subject to the confidentiality

provisions described above, Ascent provides equal parental access to information. Whether issues relate to a court or administrative order concerning coverage or simply access to information, Ascent is not a party to domestic disputes. Such matters must be resolved between parents of the dependent child.

Proof of loss: A sworn statement that usually must be furnished by the insured to an insurer before any loss under a policy may be paid. This form is usually used in the settlement of first-party losses and includes the date and description of the occurrence and the amount of loss.

Claim: A demand by an insured or another party for indemnification of a loss under an insurance policy or bond; sometimes, the actual or estimated amount of a loss.

Filing a Claim

Claims should be filed on Ascent forms. If Ascent does not provide the requested forms within fifteen (15) days after the request is made, the claim may be submitted in a letter which provides written proof of the claim covering the occurrence, the character, and the extent of the loss. The requirements for Proof of Loss will be considered satisfied if Ascent receives the Ascent forms or a written statement as outlined above within the time frame as stated in the following paragraph.

Time Limits on Filing Proof of Loss

Proof of Loss must be provided within ninety (90) days after the termination of care for which Benefits are payable. If that is not possible, it must be provided as soon as reasonably possible, but not later than three hundred sixty-five (365) days after the date of service. If the Proof of Loss is filed outside these limits, the claim will be denied. These limits will not apply should the Policyholder lack legal capacity.

Proof of Loss

Proof of Loss means written proof that the Covered Person has incurred Dental Expenses for which Dental Benefits are payable. Proof of Loss must be provided at the Subscriber's expense. No dental benefit will be paid until Proof of Loss is satisfied. Proof of loss may be submitted by United States mail either first class, or by overnight delivery service; electronically; by facsimile; or by hand delivery.

Documentation of Proof of Loss

At the Policyholder's expense, it is necessary to submit completed claim statements, with the Policyholder's or Covered Person's signed authorization for Ascent to obtain information, and any other items we may reasonably require in support of the claim. This information may be obtained from any provider or insurance company. Ascent reserves the right to reject or suspend a claim based on lack of dental information or records.

Investigation of Claims

Ascent may investigate your claims at any time. At Ascent's expense, we may have a dental professional of our choice examine the Covered Person and/or review x-rays. Ascent may deny or suspend payment of Dental Benefits if the Covered Person or the dentist providing care fails to cooperate with a review or examination by the Dental Professional that Ascent selects.

Payment of Dental Benefits

Ascent will pay all dental benefits directly to the Participating Dentists or to the Policyholder if the dentist is a Non-participating Dentist immediately after Proof of Loss is established. Ascent does not require that any covered services be provided by a specific Dentist. See the Network of Member Dentists Section of this Dental Coverage Policy for a complete description of how benefits are paid for Participating and Non-participating Dentists.

Notice of Decision on Claim

If all information needed to process the claim is submitted, Ascent will pay, deny or settle the claim within thirty (30) calendar days after receipt if submitted electronically and within forty-five (45) calendar days after receipt of claim by any other acceptable means stated above.

If additional information is needed and, therefore, Ascent is unable to pay the claim, the subscriber will receive a notice of our receipt of the claim within thirty (30) calendar days after Ascent receives the claim. If Ascent denies your claim or procedure, or reduces your payment, in whole or in part, including those due to eligibility to participate or utilization review, you will receive an Explanation of Benefits (EOB) describing your liability for services received. If you have no liability and part of your claim is denied, you will not receive an EOB. If Ascent denies your claim, the specific reason for your denial is shown on your explanation of Benefits (EOB). If additional information is required to process your claim, the EOB will show the information that Ascent needs to finish processing your claim. The plan provisions that are relied upon for processing are included in your benefit booklet. If the subscriber does not receive Ascent's decision within thirty (30) calendar days of receipt if submitted electronically and within forty-five (45) calendar days after receipt is submitted by any other means after Ascent receives information required to process the claim, the subscriber will have an immediate right to request a review as if the claim had been denied.

If Ascent denies any part of the claim, the subscriber will receive a written notice of denial containing:

- A. The reasons for the decision;
- B. A description of any additional information needed to support the claim; and
- C. Information concerning the subscriber's right to appeal the decision if applicable.

Time Limits on Legal Actions

No action at law or in equity may be brought until ninety (90) days after you have given us Proof of Loss. No such action may be brought more than three (3) years after the earlier of:

- A. The date Ascent receives the Proof of Loss, and
- B. The end of the period within which Proof of Loss is required to be given.

Claims Appeal Process

Either you or your treating provider can file an appeal on your behalf. Ascent provides a form to be used for an appeal in the center of the Appeals Packet. You are not required to use the form; a letter with the same information is acceptable. If you decide to appeal a decision to deny authorization or payment of a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

The process for an appeal is described in detail in the Appeals Packet, a separate document, which is provided to you when you become a Covered Policyholder. You can request another copy of this Appeals Packet by visiting our Web site at www.ascentbenefits.com or by calling Ascent's Customer Service Department.

Description of the Appeals Process

There are two (2) types of appeals: an expedited appeal for urgent matters, and a standard appeal. Each type of appeal has three (3) levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals (for urgently needed services you have not yet received)	Standard Appeals (for non-urgent services or denied claims)
Level 1: Expedited Medical Review	Informal Reconsideration ¹
Level 2: Expedited Appeal	Formal Appeal
Level 3: Expedited External Independent Review	External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

Ascent Benefits Company does not provide informal reconsideration of a denied claim; our appeals process begins at the formal appeal level.

Please read the information in your Appeals Packet for details about your rights and responsibilities during the appeals process. These will include the procedures Ascent and you must follow when participating in the appeals process, the time period applicable at each level of appeal, whether your request for an appeal must be in writing, and notices you will receive from Ascent regarding your appeal.

Should you have any questions regarding the appeals process and procedures, please contact Ascent at the numbers listed in your Appeals Packet. For additional assistance with questions regarding the appeals process, you may contact the Colorado Division of Insurance.